

BP \_\_\_\_\_  
DHMH-16 50M 7/77  
(VRA 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8023461																				
REG. NO.																																
1 - FOR STATE REGISTRAR			1a DECEASED NAME (TYPE OR PRINT)			1b FIRST			1c MIDDLE		1d LAST		2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR													
			JOSEPHINE			S.			ABEL		9 30 80						13 2 PM															
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR			8 IF UNDER 24 HRS																	
FEMALE			WHITE			MONTH DAY YEAR			79 YRS			MONTHS DAYS			HOURS MIN																	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY											
MARYLAND			U.S.A.			10 20 1900			FREDERICK COUNTY			MD			FREDERICK			FREDERICK NURSING CENTER			HOMEMAKER											
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS			14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			18a APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MARYLAND			BALTIMORE			DUNDALK			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3123 VULCAN ROAD, 21222			UNKNOWN			UNKNOWN			NO			UNAVAILABLE			WILLIAM R. ABEL 6502 OVERHEART LANE			56 hrs		
18b IMMEDIATE CAUSE (a)			18c DUE TO, OR AS A CONSEQUENCE OF (b)			18d DUE TO, OR AS A CONSEQUENCE OF (c)			18e APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
0701			De generative disease of liver			56 hrs			0701			De generative disease of liver			56 hrs			Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			22a SIGNATURE			22b PHYSICIAN'S NAME (TYPE OR PRINT)			22c ADDRESS			22d DATE SIGNED		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY			STATE			Glen F. Meadows Jr. MD			8101ou House Ave, Frederick, MD			Sept 30, 1980								
22a I certify that (I) this hospital attended the deceased from 1978, 19, to Sept 30, 1980, that (I) (we) last saw the deceased alive on Sept 30, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												22b ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORIAL			23d LOCATION CITY OR TOWN			23e COUNTY			23f STATE			24a FUNERAL DIRECTOR NAME			24b ADDRESS			24c DATE REC'D. BY REGISTRAR			24d REGISTRAR'S SIGNATURE					
BURIAL			10-03-80			OAK LAWN CEMETERY			EAST POINT			BALTO.			MD.			HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.			21229			OCT 2 1980			History already					

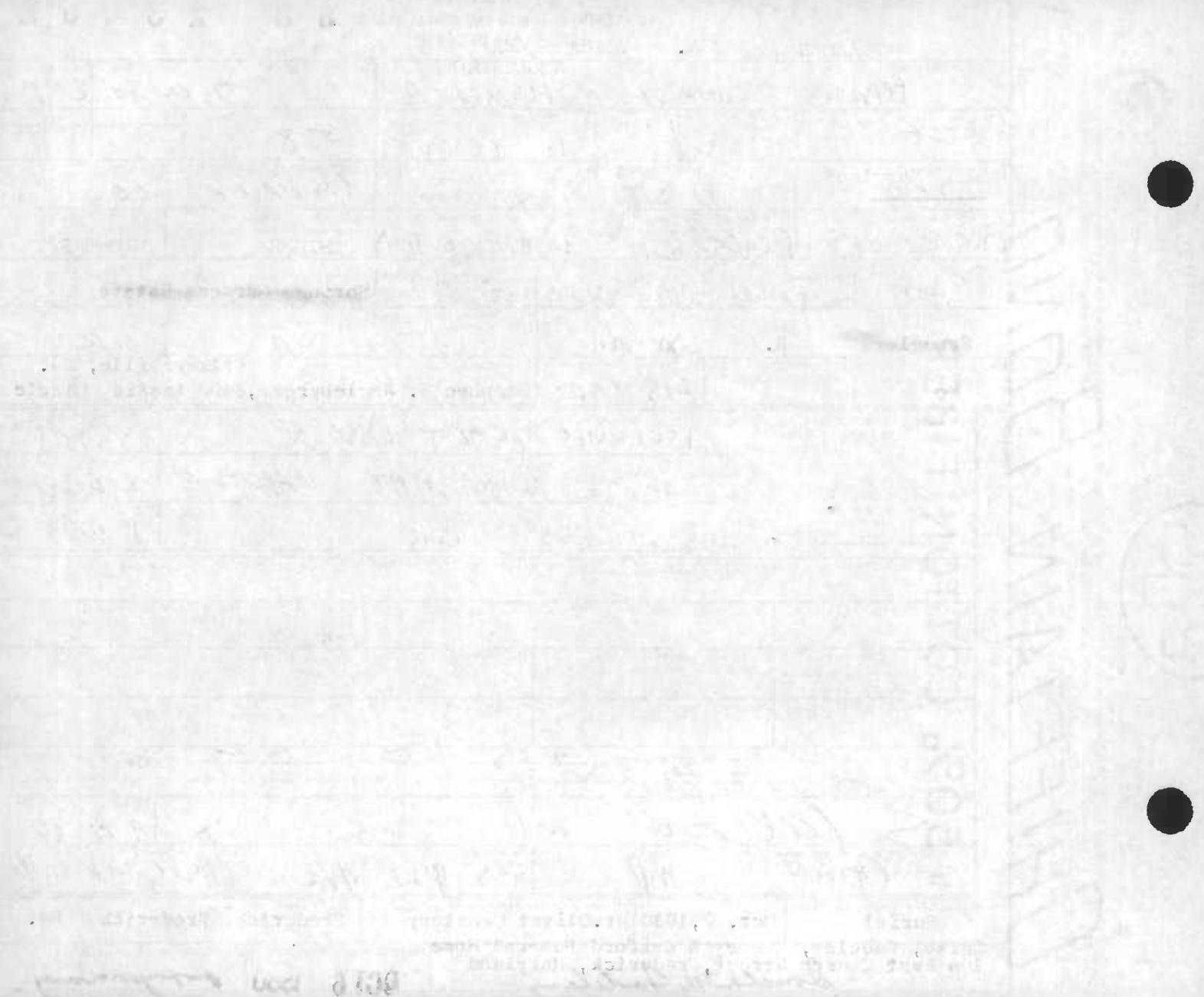


TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page \_\_\_\_\_  
rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- STATE REGISTRAR FRANCES		A. ANGLEBERGER		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 0 2 3 4 6 2						
1a DECEASED NAME (TYPE OR PRINT)		MIDDLE		ANGLEBERGER		REG. NO.						
FRANCES				ANDREW ANGLEBERGER								
3 SEX	F	4 RACE	W	5. DATE OF BIRTH	MONTH 11	DAY 12	YEAR 21	6 AGE (IN YEARS LAST BIRTHDAY)	58	IF UNDER 1 YEAR MONTHS	2 24	26 HOUR HOURS
7a BIRTHPLACE COUNTRY	MARYLAND USA	7b. CITIZEN OF WHAT COUNTRY?	USA	8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH				FREDERICK CO. MD.		
10 CITY OR TOWN OF DEATH	FREDERICK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	FREDERICK MEMORIAL HOSP	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	DESIGNER				12b KIND OF BUSINESS OR INDUSTRY	FLOWERS		
13a STATE	MD	13b COUNTY	FRED	13c CITY OR TOWN	WALKERSVILLE				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS	SPRING GARDENS ESTATE	
14 FATHER'S NAME	Samuel	MIDDLE E.	LAST SNYDER	15 MOTHER'S MAIDEN NAME	LUCY				MIDDLE D.	LAST WOLFE		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	16b. SOCIAL SECURITY NO.	215-14-9030	17. INFORMANT	Stephen E. Angleberger, 8400 Lassie Circle				ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (1a)												
410- Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause (1c)												
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION 2 WEEKS												
DUE TO, OR AS A CONSEQUENCE OF (c) 1985, STRESS UTER 1 DAY												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a I certify that (I) (this hospital) attended the deceased from 9-25, 1980, to 9-27, 1980, that (I) (we) last saw the deceased alive on 9-26, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b. SIGNATURE		S. Kahan		MD		DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		S. Kahan		MD		22e. ADDRESS	9-27, 80					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Oct. 2, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION Frederick		Frederick MD				
24 FUNERAL DIRECTOR 106 East Church Street, Frederick, Maryland		24a. Name John Keeney, Keeney & Bastford Funeral Home		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE						
BP _____		2701		OCT 6 1980		John Keeney						
DHMH-T6 30M 2/80 (VRA 15, 4)												



1. DECEASED NAME (TYPE OR PRINT)			FIRST Ralph	MIDDLE Edward	LAST Arvin	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	MONTH 9	DAY 21	YEAR 1980	2b. HOUR M 3:15			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Dec.	DAY 2	YEAR 1958	6. AGE (IN YEARS (LAST BIRTHDAY) 21 YRS.	7. IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0	7d. HOUR P.M.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		<input checked="" type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.			
10. CITY OR TOWN OF DEATH Knoxville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3718 Mountain Rd. (in car)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-Operator			12b. KIND OF BUSINESS OR INDUSTRY Produce Stand					
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Jefferson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2634-B Lander Road 21755					
14. FATHER'S NAME Albert		MIDDLE S. E.	LAST Arvin	15. MOTHER'S MAIDEN NAME Mary		FIRST S.	MIDDLE Stottlemeyer	LAST LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218 80 2772	17. INFORMANT Barbara Ritchie	ADDRESS 2634-B Lander Road Jefferson, Md. 21755
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 2:28 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted		21d. LOCATION IN front of CITY OR TOWN 3718 Mountain Rd. Knoxville Frederick Md.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) in car on street		21f. TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED 9/22/80	
23a. EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.			23b. ADDRESS 111 Penn Street		23c. NAME OF CEMETERY OR CREMATORIUM Sept. 24, 1980 Lutheran Cemetery						
23d. LOCATION CITY OR TOWN Jefferson, Maryland		23e. DATE REC'D. BY REGISTRAR 23b. REGISTRAR'S SIGNATURE John T. Williams Funeral Home Brunswick, Md. 21026 1980 Harry McCreasy						23c. COUNTY Jefferson		23d. STATE Maryland			
24. FUNERAL DIRECTOR NAME John T. Williams Funeral Home Brunswick, Md.		25a. DATE REC'D. BY REGISTRAR 23b. REGISTRAR'S SIGNATURE John T. Williams Funeral Home Brunswick, Md. 21026 1980 Harry McCreasy											
BP		DHMH - 17 (VR A15 ME (5)) 15M 7/76											

100-3932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

BP \_\_\_\_\_

DHMH-16 25M  
(VRA 15, 4) 1/791 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 4 6 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST Park	MIDDLE Albert	LAST BEACHLEY	2a. DATE OF DEATH September 24, 1980	MONTH SEP	DAY 24	YEAR 1980	2b. HOUR M
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Oct.		DAY 1	YEAR 1904	6. AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR MONTHS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7c. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD		IF UNDER 24 HRS HOURS MIN			
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farming		12b. KIND OF BUSINESS OR INDUSTRY -----					
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 469 Carrollton Drive			
14. FATHER'S NAME FIRST Albert		MIDDLE C.		LAST Beachley		15. MOTHER'S MAIDEN NAME FIRST Catherine		MIDDLE C.		LAST Bowlus	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO 214-36-0482		17. INFORMANT Mrs. Katherine R. Beachley, same as above in item #13e.		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY 4140		IMMEDIATE CAUSE (a) 4140		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i>							
				DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Parasenior Parkinsonism, Arterial Arteriosclerosis - Prostate Hypertrophy</i>											
19a. DATE OF OPERATION Sept. 12, 1980		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostate Hypertrophy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>1963</u> to <u>19</u> to <u>Sept 24, 1980</u> , that (1) (we) last saw the deceased alive on <u>Sept 24, 1980</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.											
22b. SIGNATURE <i>Gilcin F. Meaders</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/20/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Gilcin F. Meaders, MD		22e. ADDRESS 810 Toll House Ave., Frederick, Md. 21701									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 27, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cem.		23d. LOCATION CITY OR TOWN Frederick		COUNTY Frederick	STATE Md.		
24. FUNERAL DIRECTOR Smith Wadeley Keeney Basford Funeral Home		ADDRESS 106 E. Church St. Frederick, Md.		RECD. BY REGISTRAR SEP 30 1980		REGISTRAR'S SIGNATURE <i>John McAleney</i>					

2010.2.20

M

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8023465							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
Gilmore A.					Bentley	9 21 80					4:30 PM								
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				7b. HOUR								
M.		Negroid		MONTH	DAY	YEAR	74	8 UNDER 1 YEAR	9 OVER 1 YEAR	10 MONTHS	11 DAYS	12 HOURS							
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR COUNTRY		
Frederick, Md.		USA		4 13 06			Frederick				Frederick, Md.		Frederick Memorial Hospital		Lab. Tech.		NIH		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		104 S. Market St.							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Unknown					.	Carrie			A.		Bentley	no		213-12-7593A		Ernest E. Lee		Frederick, Md.	
18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRO-VASCULAR disease (diffuse)																			
4399 Conditions, if any, which gave rise to immediate cause in stating the underlying cause lost { b c DUE TO, OR AS A CONSEQUENCE OF																			
DUE TO, OR AS A CONSEQUENCE OF c PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE										
22a. I certify that (1) the hospital attended the deceased from (17) July 19 80 to (21) Sept 19 80, that (1) (we) last saw the deceased alive on (20) Sept 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.												22c. DATE SIGNED 21 Sept 80							
22b. SIGNATURE George L. Smith Jr. 42-						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/23/80			23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery			23d. LOCATION CITY OR TOWN Frederick			COUNTY MD.							
24. FUNERAL DIRECTOR G. Douglas Stauffer			ADDRESS Rt. 10, Frederick, Md.			25. DATE REC'D. BY REGISTRAR SEP 25 1980													

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8023466				
										REG. NO.				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR 10:30 A.M.				
1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST							
WALLACE			CLAY				BOWSER							
3 SEX			4 RACE		5 DATE OF BIRTH MONTH DAY YEAR									
Male			Caucasian		May 18, 1901									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
Pa.			U.S.A.											
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
Middletown			505 E. Main St.											
13a STATE Md.			13b COUNTY Fred.		13c CITY OR TOWN Middletown			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 505 E. Main St.			
14 FATHER'S NAME JAMES			MIDDLE IRVING		LAST BOWSER			15 MOTHER'S MAIDEN NAME ANNA			MIDDLE MAE		LAST COY	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS Mary Bowser Middletown, Md. 21769									
No			716-14-5969											
18 CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ASCVD & CHF arrhythmia hours ASCVD & Hypertension years											
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)			DUE TO, OR AS A CONSEQUENCE OF (b)											
			DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED							20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from 4-19-79 to 9-10-80, that (I) (we) last saw the deceased alive on 12-19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE Charles R. Wierer MD			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							22c DATE SIGNED 9-10-80				
22d PHYSICIAN'S NAME (TYPE OR PRINT) Charles R. Wierer			22e ADDRESS Myersville, Md.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Sept. 13, 1980		23c NAME OF CEMETERY OR CREMATORIAL Scottdale Cem.			23d LOCATION CITY OR TOWN Scottdale Westmoreland Pa.		23e COUNTY STATE Westmoreland Pa.				
24 FUNERAL DIRECTOR NAME Gladhill Co.			25a DATE REC'D. BY REGISTRAR SEP 16 1980							25b. REGISTRATION SIGNATURE Loyalty Agency				
Middletown, Md. 21769														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 3 4 6 7				
REG. NO.														
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
			RAYMOND WILLIAM BURDETTE Jr.						9/13/80			8:00 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male			White			May 22 1922			58 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U.S.A.						Frederick County, MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Frederick			Frederick Memorial Hospital			Laborer			Asphalt Co.					
13a STATE			13b COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS		
Maryland			Frederick			Frederick						7601 Old Receiver Road, Shookstown		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Raymond			W. Burdette Sr.			Fannie M. Mercer								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
no			220-03-1468			Mrs. Margaret J. Burdette, same as above in item #13e								
18. CAUSE OF DEATH (Enter only one cause per line for 18, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Respiratory Failure				
496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.										DUE TO, OR AS A CONSEQUENCE OF (b) Severe Chronic Obstructive Pulmonary Disease				
										DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										10 years				
Heavy Cigarette Smoker														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
/						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>Sept. 2 1980</u> to <u>Sept. 13 1980</u> that (I) (we) last saw the deceased alive on <u>Sept. 12 1980</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
James S. Grisson M.D.									9/13/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN		
James S. Grisson M.D.			198 Thomas Johnson Dr. Suite 4 Frederick, Md.			Burial			Rocky Springs Cem.			Frederick Frederick Md.		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE ADDRESS			25b. RECD. BY REC'D. BY REC'D. BY REC'D.					
Smith Fahey Keeney Bassford Funeral Home			106 E. Church St., Frederick, Md. 21701			Sep 17 1980								

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4  
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 3 4 6 8  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
LILLIAN Rebecca Bussard					9/23	1980			11 A M			
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)					
Female		White		Oct. 3 1909			70	70	70			
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8			IF UNDER 1 YEAR MONTHS DAYS					
Maryland		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			MONTHS DAYS					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a BALTIMORE CITY OR COUNTY OF DEATH			12b KIND OF BUSINESS OR INDUSTRY				
Frederick		Frederick Memorial Hospital			Frederick County, MD			- - - - -				
13 STATE Maryland		13a COUNTY Frederick		13c CITY OR TOWN Frederick			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 315 Braddock Avenue		
14 FATHER'S NAME Henry		MIDDLE T. Remsberg		15 MOTHER'S MAIDEN NAME Alverta			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO 214-48-2692		
16c PART 1 DEATH WAS CAUSED BY		17 INFORMANT Mrs. Margaret V. Hoffman, 315 Braddock Ave., Frederick, Maryland			18 CAUSE OF DEATH Enter only one cause per line for a, b, and c PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE 4409			18b APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
					DUE TO, OR AS A CONSEQUENCE OF b. Senility							
					DUE TO, OR AS A CONSEQUENCE OF c. Arteriosclerosis							
19a MEDICAL CERTIFICATION		20a PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cavaging, Seizure disorder			20b CONDITION FOR WHICH OPERATION WAS PERFORMED			20c AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19b DATE OF OPERATION		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above (I) (we) (did) (did not) view the body after death.		22b SIGNATURE James Fizzell			22c DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED 9/23/80	
22e PHYSICIAN'S NAME (TYPE OR PRINT) James Fizzell		22f ADDRESS 300 Park Ave, Frederick										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Sept. 26, 1980		23c NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery			23d LOCATION CITY/TOWNSHIP Middletown			23e COUNTY Md.		
24a PERSON BURIED Same Smith, Fodeley, Keeney		24b BURIAL, CREMATION, REMOVAL Same 106 E. Church St., Frederick, Md.		24c DATE Sept. 26, 1980			24d BURIAL, CREMATION, REMOVAL Same Baird Funeral Home			24e COUNTY Md.		
25a REGISTRATION BP		25b REGISTRATION DHRM - 1660M 1/75 (VRA 15 (4))		25c REGISTRATION 9/20/80			25d REGISTRATION Same			25e REGISTRATION Same		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be secured within 24 hours after death. Right 3 in  
retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, right 3 in  
should be detached for use as the burial and funeral program. Then please remove carbon program. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

Medical Examiner No. 71-116

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 8023469											
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR		
MARY			Clara Chapline			Sept. 25, 1980			9 11 80		
SEX Female			4 RACE CAU			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		
BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.			Sept. 25, 1901			78		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Frederick								
10 CITY OR TOWN OF DEATH Frederick			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Frederick Memorial Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife			12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland			13b COUNTY Frederick			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 105 A. Council St.		
14 FATHER'S NAME FIRST MIDDLE LAST Richard Kelly			15 MOTHER'S MAIDEN NAME Katherine S. Barton								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 215-10-2029			17 INFORMANT Mary Chapline			18d MARY TINTERVAL BETWEEN ONSET AND DEATH		
18b CAUSE OF DEATH Enter only one cause per line for 18a, 1b, and 1c PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18c DUE TO, OR AS A CONSEQUENCE OF b) Thrombophlebitis, Right leg			18d DUE TO, OR AS A CONSEQUENCE OF c) ARTERIOSclerosis			18e		
4409 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 8 25 1980			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Fell in bathroom			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from 9/25/80 to 9/11/80, that (2) we last saw the deceased alive on 9/11/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (3) we did not view the body after death.			22b SIGNATURE Robert R. Roberts			22c DEGREE DEGREE			22d DATE SIGNED 9/13/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT R. ROBERTS			22e ADDRESS 15 W 7th St. Frederick MD 21701								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 9/16/80			23c NAME OF CEMETERY OR CREMATORIAL Gettysburg Nat. Cemetery			23d LOCATION CITY OR TOWN Gettysburg COUNTY Adams STATE Pa.		
24 FUNERAL DIRECTOR NAME Dailey Funeral Home			ADDRESS 1201 N. Market St. Frederick, Md. 21701			25a DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 19 1980 - Robert J. Brady					

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 48 hours after death by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be sent with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal

IMPORTANT If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 3 4 1 0 CERTIFICATE OF DEATH												
1 - FOR STATE REGISTRAR				REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	
Katherine Estella Cheatham						9/19/80						
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			26 HOUR		
Female		White		July 20 1904			76			11:30 PM		
7a BIRTHPLACE STATE OR FOREIGN COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8			IF SINGLER = 1 YEAR MONTHS DAYS			11 MONTHS 24 HRS HOURS MIN		
Virginia		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			9 BALTIMORE CITY OR COUNTY OF DEATH		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										
Fredrick		Frederick Memorial Hospital										
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?			13e STREET ADDRESS			
Maryland		Frederick		Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Ship 100 North Court Street			
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME			LAST				
Joseph				Hoffman	Minnie			Harris				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT			ADDRESS					
no		- - - - - 214-10-5746		Mr. John R. Cheatham, 100 North Court St., Frederick, Maryland			APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH					
18 CAUSE OF DEATH Enter only one cause per line for part 1a and c PART 1 DEATH WAS CAUSED BY												
IMMEDIATE CAUSE a 436- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last												
DUE TO OR AS A CONSEQUENCE OF b: <i>Cardiac &amp; Hyp. Anx.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Recent Court Case, Death</i>												
19 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c HOW INJURY OCCURRED			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN		COUNTY STATE		
22a I certify that (I) this hospital attended the deceased from 9/19/80 to 9/19/80, that (I) we last saw the deceased alive on 9/19/80 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) we did/did not view the body after death.												
22b SIGNATURE <i>R. L. Kaufmann, M.D.</i>		22c DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			22f DATE SIGNED							
Dr. R. L. Kaufmann M.D.		804 Toll House Ave., Fred. Md. 21701			9/19/80							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL			23d LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		Sept 12, 1980		Mt. Olivet Cemetery			Frederick		Frederick		Md.	
24 FUNERAL DIRECTOR NAME		24a DATE REC'D. BY REGISTRAR			24b REGISTRAR'S SIGNATURE							
Fadel Keeney Bedford Funeral Home 106 E. Church St., Frederick, Md. 21701		SEP 15 1980			Larry McCready							

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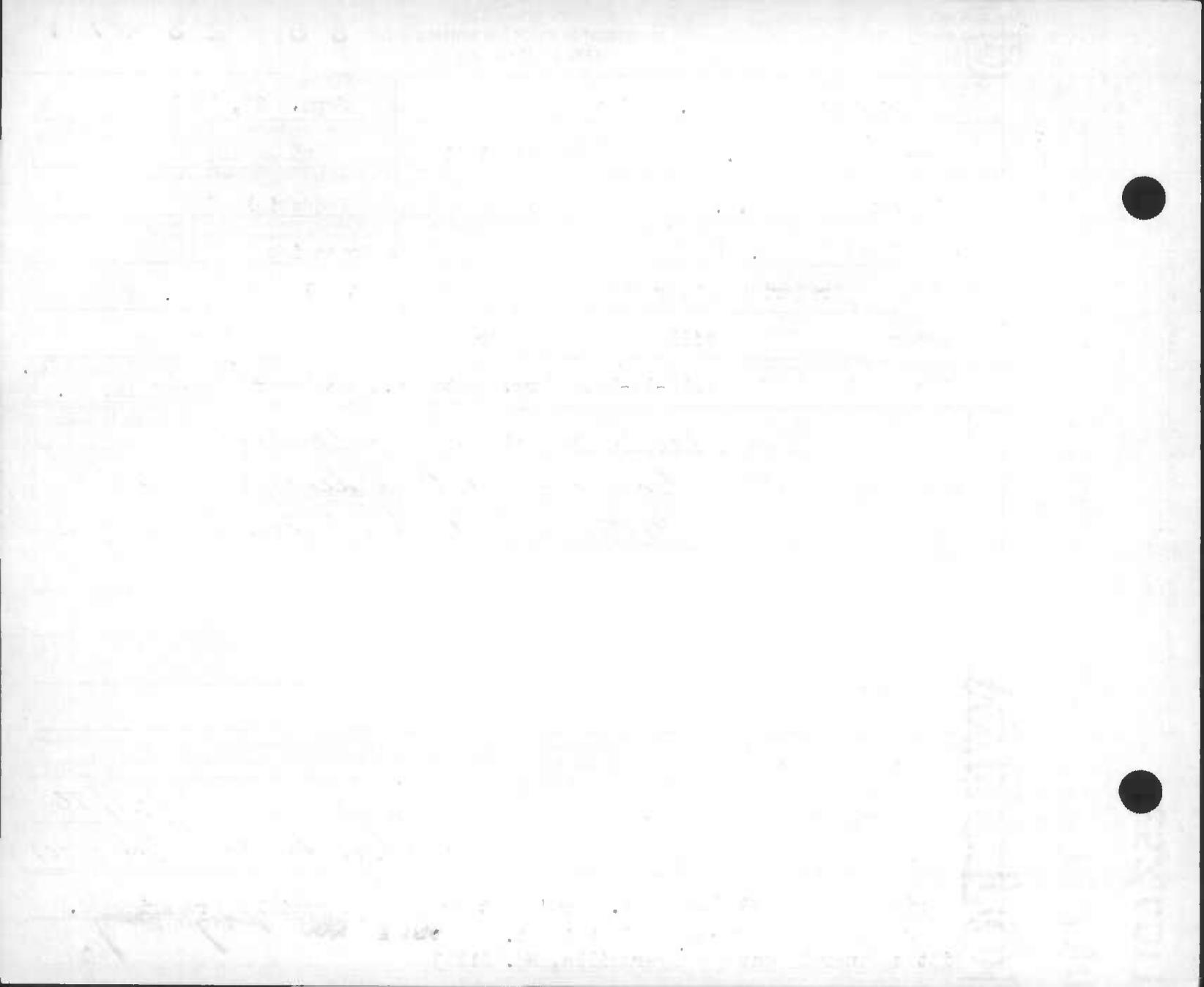
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						80 23471		
						REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR			
Mildred L. Cline			Sept. 27, 1980		M			
3. SEX Female		4. RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR May 21 1911		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick MD		
10. CITY OR TOWN OF DEATH Myersville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. #1		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #1		
14. FATHER'S NAME Lester		15. MOTHER'S MAIDEN NAME Naillé		16. SOCIAL SECURITY NO. 218-34-3632		17. INFORMANT Mrs. Raetta M. Stotelmeyer		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN)		18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18c. ADDRESS 3337 Black Rock Rd. Myersville, Md.				
No								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost		Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease		5 yrs		
				DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease		10 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE
22a. I certify that (i) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (i) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated in item 18.								
22b. SIGNATURE F. R. Poirier		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9/28/80				
22e. PHYSICIAN'S NAME (THE DECEASED) F. R. Poirier		22f. ADDRESS 700 Montclair Dr., Fred. Md. 21701						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/30/80		23c. NAME OF CEMETERY OR CREMATORIAL St. Mark's Lutheran		23d. LOCATION CITY OR TOWN Wolfesville		
24. FUNERAL DIRECTOR NAME <i>Alverna E. Ricketts</i> ADDRESS 504 Main St. Bittle Funeral Home		NOTE E.C.D.		24e. ILLUSTRATOR'S SIGNATURE		24f. REGISTRAR'S SIGNATURE 24g. 24h.		
DHMH-16 20M (VRA 15, 4) 7/78								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 0 2 3 4 7 2			
												REG. NO.			
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			MADGE MIDDLE EVELYN LAST COX			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
			MADGE EVELYN			COX			9 11 80						2:55 PM
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS		
Female			White			Sept. 24, 1915			64			YRS.	MIN.		
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			USA									Frederick County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Frederick			Frederick Memorial Hospital						Retired Bookkeeper Furniture						
13a. STATE Maryland			13b. COUNTY Frederick			13c. CITY OR TOWN Brunswick			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 123 Florida Avenue 21716			
14. FATHER'S NAME FIRST William			MIDDLE C.			LAST Ritenour			15. MOTHER'S MAIDEN NAME FIRST Myrtle			16. ADDRESS 123 Florida Avenue Brunswick, Md. 21716			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No			215 07 3689			Gaylord F. Cox									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>respiratory arrest</u>															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>colon nec sepsis</u>												1 d			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>granulocytopenia</u>												2 d			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.															
colitis carcinoma															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 14</u> 19 <u>80</u> to <u>July 11</u> 19 <u>80</u> , that (I) (we) last saw the deceased live on <u>July 10</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (I) did not view the body after death.															
22b. SIGNATURE <u>B. Carter</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>9/14/80</u>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS <u>4 West Street</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Sept. 14, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Park Heights Cem.			23d. LOCATION CITY OR TOWN Brunswick, Maryland			CITY		COUNTY	STATE
24. FUNERAL DIRECTOR NAME John T. Williams			100 Petersville Road			25a. DATE REC'D. BY REG. YR/PA			25b. REGISTER'S SIGNATURE <u>John T. Williams</u>						
						SEPT. 1980									

2000-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be dated for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	0	2	3	4	7	3
1 - FOR STATE REGISTRAR										REG. NO.						
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR							
Mary Elizabeth CRAMPTON						Sept. 9, 1980			7:15 PM							
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 74 HRS				
Female		White		NOV. 3, 1894			85			MONTHS	DAYS	HOURS	MIN			
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland		U.S.A.					Frederick County									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY									
Frederick		503 Biggs Avenue		Clerical			College									
13a STATE		13b COUNTY		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS									
Maryland		Frederick					503 Biggs Avenue									
14 FATHER'S NAME		MIDDLE		15 MOTHER'S MAIDEN NAME			16 ADDRESS									
Charles		Lee		Null			503 Biggs Avenue									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT			Frederick, Maryland									
No		None		216-22-7721			Mrs. J. Alfred Cutsail,									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 yrs						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost</i>																
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Old myocardial infarcts x 2 + heart failure</i>																
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE												
22a I certify that (I) (this hospital) attended the deceased from <i>3-16-58</i> to <i>9-7-80</i> , to <i>19 50</i> , that (I) (we) last saw the deceased alive on <i>9-8-1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (did) (did not) view the body after death.																
22b SIGNATURE <i>Bet R Martin MD</i> DEGREE										22c DATE SIGNED <i>9-11-80</i>						
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN								
Bet R Martin		220 N Market Frederick Md														
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Sept 12, 1980		23c NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d LOCATION Frederick, Frederick, Md. STATE										
24 FUNERAL DIRECTOR Smith, Fadley, Keeney, Basford Funeral Home 106 East Church St., Frederick, Md. 21701				24c DATE RECEIVED BY REGISTRAR SEP 15 1980		24d REGISTRATION SIGNATURE <i>Longfellow</i>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 &amp; 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it may be detached for use at the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CROWN CERTIFICATE OF DEATH												8023474
											REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
FRANCES CELIA			Crown			Sept 9 1980			8:30 PM			
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR May 10, 1927			6. AGE (IN YEARS LAST BIRTHDAY) 53		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Frederick Co.			
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Md.			13b. COUNTY Frederick			13c. CITY OR TOWN Middletown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6 Larch Lane	
14. FATHER'S NAME FIRST MIDDLE LAST JENNINGS JUDY SWECKER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA STERRETT						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 226-38-7223			17. INFORMANT James Crown Middletown, Md. 21769			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Emphysema</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>NA</i>												
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>NA</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>NA</i>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 4 1980</i> to <i>Sept 7 1980</i> , that (I) (we) last saw the deceased alive on <i>Sept 7 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.												
22b. SIGNATURE <i>Lloyd Halverson</i>			22c. DEGREE			22d. DATE SIGNED <i>9/7/80</i>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lloyd Halverson</i>			22f. ADDRESS <i>198 Thomas Johnson Dr</i>									
23a. BURIAL, CREMATION, REMOVAL (SPEC#) Burial			23b. DATE Sept. 9, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Bluegrass Cem.			23d. LOCATION CITY/TOWN Bluegrass Highland			
24. FUNERAL DIRECTOR NAME Gladhill Co. Middletown, Md. 21769			ADDRESS			25a. DATE RECD. BY REGISTRAR <i>SEP 11 1980</i>			25b. REGISTRAR'S SIGNATURE <i>John W. Brady</i>			

6

1936

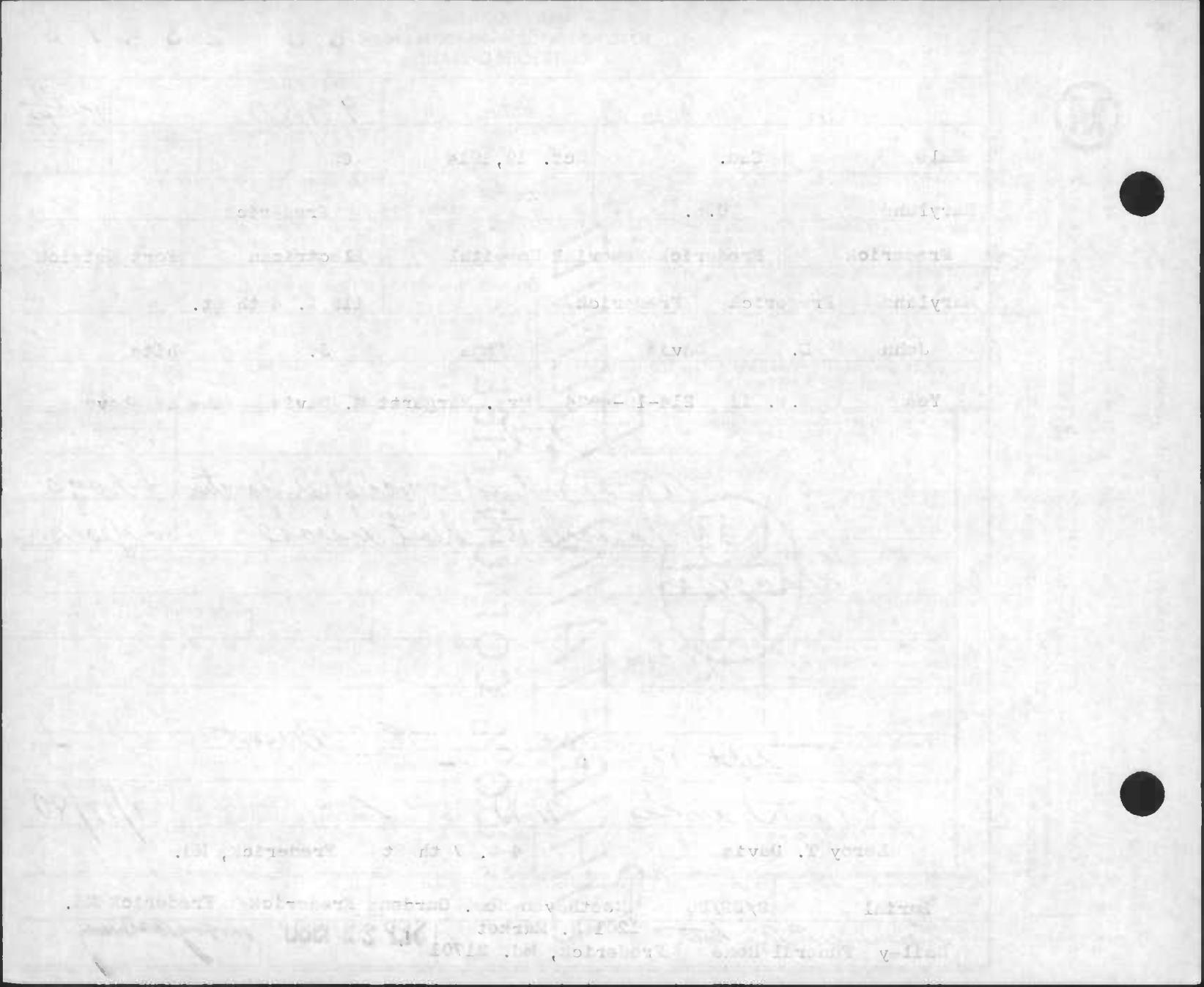
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8023475		
REG. NO.														
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST		
			John William B. Davis											
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR		
Male			Cau.			Oct. 19, 1914			65			40		
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			12b. IF UNDER 18, YEAR MONTH DAYS HOURS MIN		
Maryland			U.S.						Frederick			MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Frederick			Frederick Memorial Hospital			Electrician			Fort Detrick					
13a. STATE Maryland			13b. COUNTY Frederick			13c. CITY OR TOWN Frederick			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 115 E. 4 th St.		
14. FATHER'S NAME John L. Davis						15. MOTHER'S MAIDEN NAME Emma J. White								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes W. W. II			214-10-4924			Mrs. Margaret M. Davis same as Above						5 min		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY														
IMMEDIATE CAUSE (a) <i>asystole</i> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute anterior myocardial infarction</i> 4 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <i>Arterosclerotic heart disease</i> 2 years.														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Diabetes</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (he) attended the deceased from <i>May 17, 1980</i> to <i>Present</i> 19 that (I) (he) last saw the deceased alive on <i>Sept 17, 1980</i> and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (he) did not see the deceased after death.														
22b. SIGNATURE <i>L. T. Davis</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>9/17/80</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 4 W. 7 th St Frederick, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9/22/80			23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Mem. Gardens Frederick			23d. LOCATION CITY OR TOWN Frederick Md. STATE County Frederick Md.					
24. FUNERAL DIRECTOR <i>Frederick Dailey</i>			ADDRESS Frederick, Md. 21701			25. DATE OF BURIAL OR Cremation <i>SEP 22 1980</i>			25b. REASON FOR DEATH <i>myocardial infarction</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8023476	
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST Ruth	MIDDLE Virginia	LAST DOLL	2a DATE OF DEATH MONTH DAY YEAR September 16, 1980					16 HOUR 10:50 A M
3 SEX Female			4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1894			6 AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.			
10 CITY OR TOWN OF DEATH Frederick			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Frederick Nursing Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Person			12b KIND OF BUSINESS OR INDUSTRY Retail Selling			
13a STATE Maryland			13b COUNTY Frederick		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 127 West Third Street			
14 FATHER'S NAME FIRST Thomas			MIDDLE Ashby	LAST Locke, Sr.	15 MOTHER'S MAIDEN NAME FIRST Mae			MIDDLE Virginia	LAST Willingham		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO None		17 INFORMANT Mrs. Virginia Fry,			ADDRESS 305 Magnolia Avenue Frederick, Md. 21701			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension + generalized arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fractured L-1-4, Gangrenous foot + recent above knee amputation. Senility											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR AM MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from 1-14, 1956, to 9-16-80, 19, that (I) (we) last saw the deceased alive on 9-11-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c DATE SIGNED 9-18-80	
22b SIGNATURE Rex R. Martin, M.D.			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Rex R. Martin, M.D.			22e ADDRESS 220 North Market St., Frederick, Md. 21701								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 19, 1980		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			23d LOCATION CITY OR TOWN Frederick, Frederick, Md.		23e COUNTY Frederick, Frederick, Md.	
24 FUNERAL DIRECTOR Smith, Fadley, Keeney, Basford Funeral Home 106 East Church St., Frederick, Md. 21701			25a DATE REC'D. BY REGISTRAR SEP 22 1980					25b REGISTRAR'S SIGNATURE Anthony McAleney			

M

000 08926

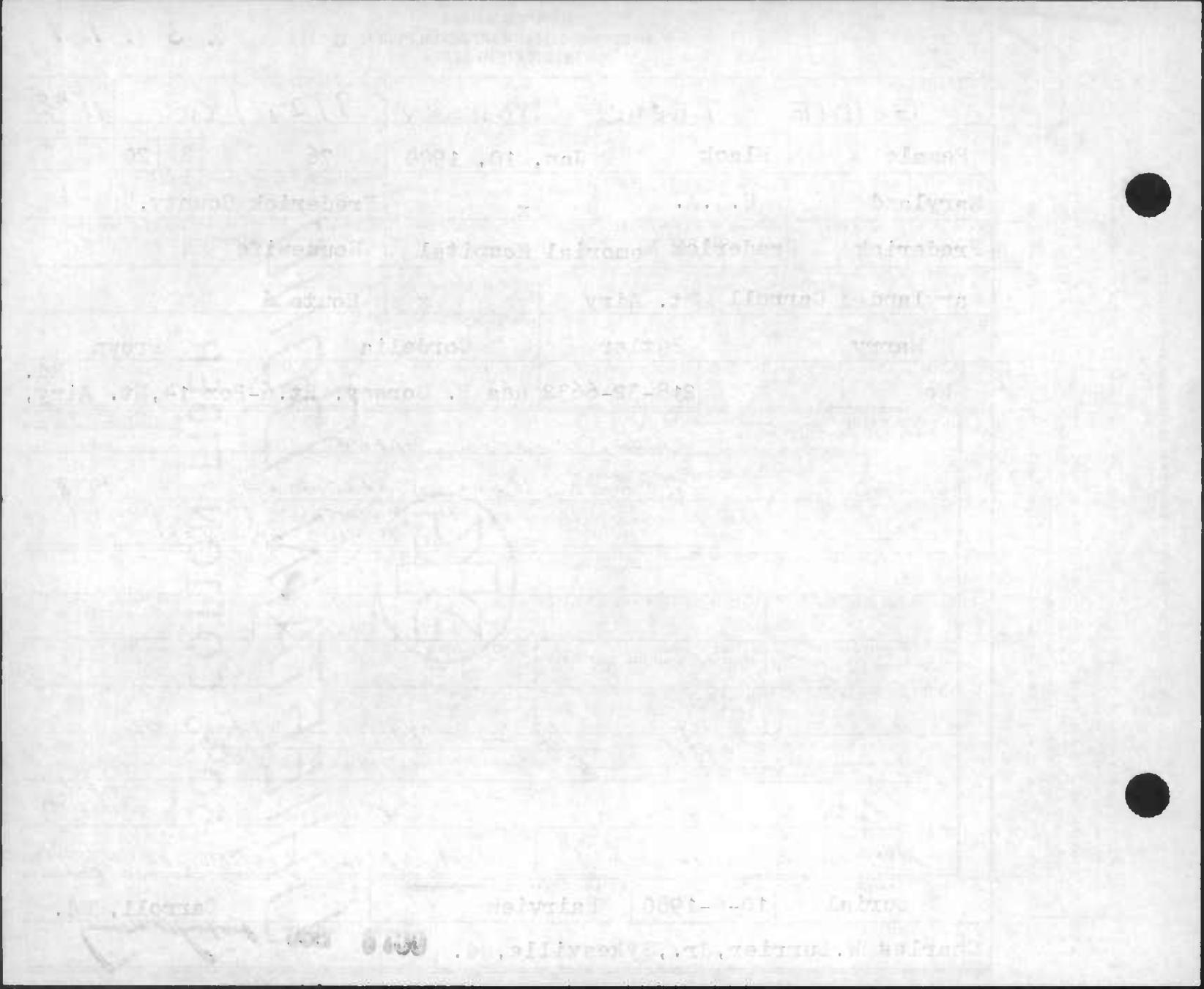
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 3 4 7 1			
REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR		
GOLDIE Irene Dorsey						9/30/80					11 45 AM		
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)					7b. IF UNDER 1 YEAR MONTHS HOURS MIN	
Female			Black		Jan. 10, 1904		76					8 20	
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD						
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME OF SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife					17b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET ADDRESS Route 6	
14. FATHER'S NAME Harry			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Cordelia					LAST Brown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 218-32-6632		17. INFORMANT Asa B. Dorsey, Rt. 6-Box 14, Mt. Airy, Md.					ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<u>1830</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost (b) <u>TERMINAL OVARIAN CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>WITH METASTASES TO LUNGS AND ABDOMEN</u> DUE TO, OR AS A CONSEQUENCE OF												1978	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET					CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-19-79</u> to <u>9/30/80</u> , that (I) (we) last saw the deceased alive on <u>9/30/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												22c. DATE SIGNED <u>10/1/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <u>Arthur G. Morris, M.D.</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 10-4-1980		23c. NAME OF CEMETERY OR CREMATORIAL Fairview		23d. LOCATION CITY OR TOWN		23e. COUNTY Carroll, Md.		STATE		
24. FUNERAL DIRECTOR Charles W. Burrier, Jr., Sykesville, Md.			25. DATE REC'D. BY REGISTRAR Oct 6 1980					25e. SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 3 4 7 8 CERTIFICATE OF DEATH												
REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR			
Clarence Edward Fogle						9 9 80			8:35 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDERS 1 YEAR MONTHS DAYS HOURS MIN.		
male		white		6 10 1903			77xx			YRS.		
7a BIRTHPLACE (COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		USA					Frederick					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A CITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK AND POSITION OF WORKING IF ANY)			12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		Frederick Memorial Hospital		molder			Iron & Steel					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland		Frederick		Woodsboro						10121 Woodsboro Rd.		
14. FATHER'S NAME		15. MOTHER'S NAME		16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
John		William Fogle		213-10-2100			Mrs. Cosgrave			Adamstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>Carcinoma of Lung</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
1629 Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause (b): DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) <del>the</del> hospital attended the deceased from <u>9/1/80</u> 19 to <u>9/4/80</u> 19 that (I) was lost saw the deceased alive on <u>9/1/80</u> 19 and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>did not</del> view the body after death												
22b. SIGNATURE <i>Anton J. Scarpa</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>9/4/80</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/12/80		23c. NAME OF CEMETERY OR CREMATORIUM Rocky Hill Cemetery			23d. LOCATION Woodsboro Fred. Md.					
24. FUNERAL DIRECTOR G. Douglas Stauffer Rt. 10 Fred. Md.		25a. DATE REC'D. BY REGISTRAR 0616 1980			25b. REGISTRAR'S SIGNATURE <i>Henry Murphy</i>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS OF DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 23479	
1- STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT) Robert Andrew Frayer						2a DATE KNOWN OF DEATH ESTI- MATED			2b HOUR MONTH DAY YEAR 9 18 80 M	
3 SEX male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR July 26 1955	6 AGE (IN YEARS LAST BIRTHDAY) 25 yrs.	7 IF UNDER 1 YR. MONTHS DAYS	8 IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			2d HOUR MONTH DAY YEAR 9 18 80 2:15A				
7a BIRTHPLACE STATE OR FOREIGN COUNTRY Michigan		7b CITIZEN OF WHAT COUNTRY? USA			8. MARRIED WIDOWED NEVER MARRIED DIVORCED X			9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County MD					
10 CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver			12b KIND OF BUSINESS OR INDUSTRY Motor Line		
13a STATE Va.		13b COUNTY		13c CITY OR TOWN Manassas		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS					
14 FATHER'S NAME FIRST James		MIDDLE Blair		LAST Frayer		15. MOTHER'S MAIDEN NAME FIRST Lorraine		MIDDLE Louise		LAST Mollison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 251-84-0372		17. INFORMANT James B. Frayer		ADDRESS Route 1 L Box 104 Noatsville, W. Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8150 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:06A 9718 19 80			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of tractor trailer/fixed object impact								
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway			21f. LOCATION STREET US 40 and 340,		CITY OR TOWN		COUNTY Frederick Co. MD				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE Hormez R. Guard, M.D.		TITLE (SPECIFY) M.D. Assistant						DATE SIGNED 9/18/80					
EXAMINER'S NAME TYPE OR PRINT)		ADDRESS 111 Penn Street Baltimore, MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 20/80		23c. NAME OF CEMETERY OR CREMATORY Locust Grove Cemetery, Noatsville, Barbourville		23d. LOCATION CITY OR TOWN Locust Grove Cemetery, Noatsville, Barbourville		23e. COUNTY Barbourville		23f. STATE W. Va.			
24. FUNERAL DIRECTOR SHARDA F. H. 2829 HUDSON ST.						25a. DATE REC'D. BY REGISTRAR SEP 25 1980		25b. REGISTRAR'S SIGNATURE Hormez R. Guard					
DMMH 17 IVR A15 ME (5) 15M 7/76													

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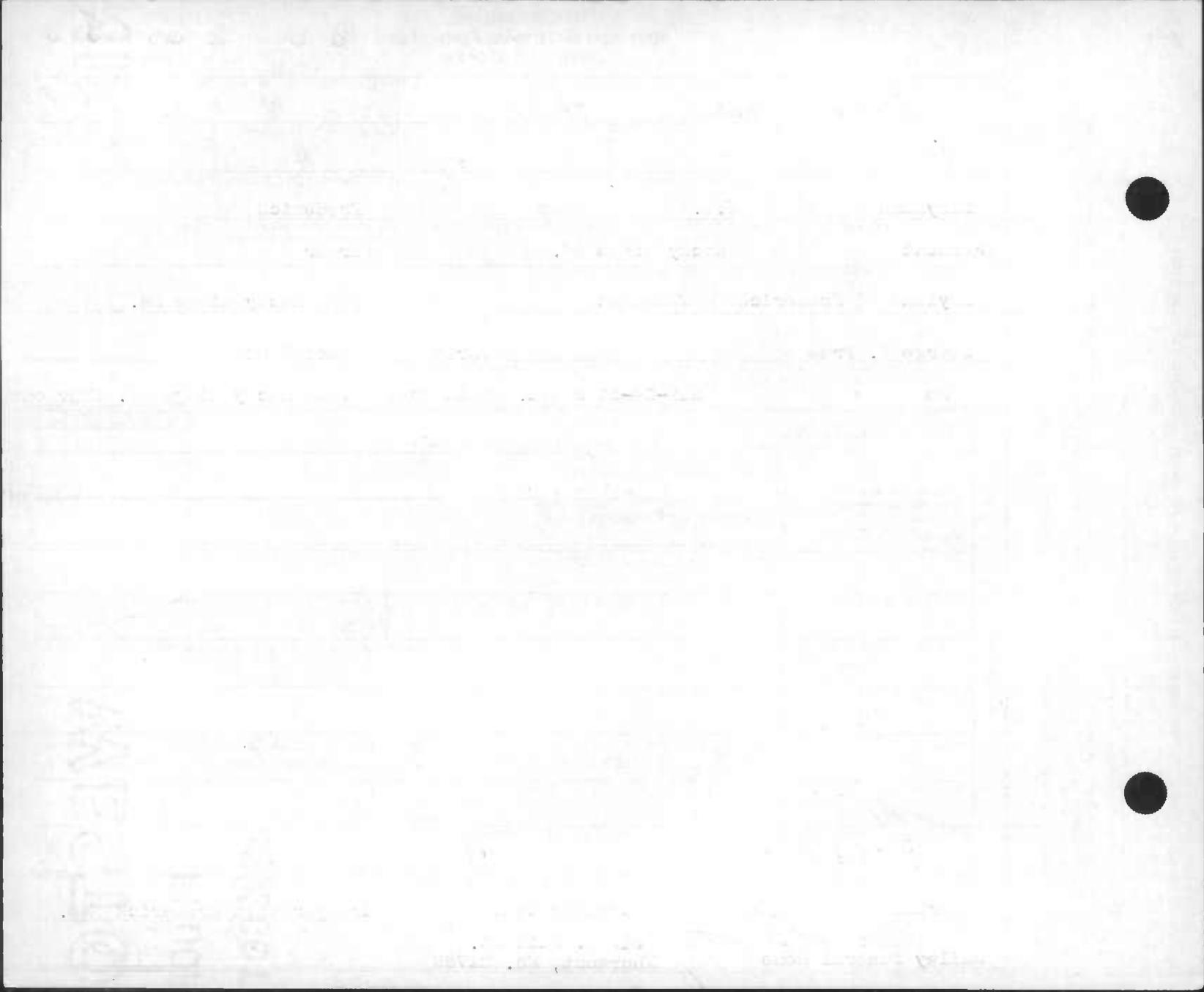
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8023480				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Byron			Edwin				FREE		9 4 80					12:10 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
M		W		MONTH DAY YEAR		96		MONTHS DAYS		HOURS MIN				
2. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland		U.S.				Frederick								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Thurmont		8003 Rocky Ridge Rd.		Farmer										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland		Frederick		Thurmont		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8003 Rocky Ridge Rd.						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
George W. Free						Sarah		Geisbert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No		212-24-5235		C. Edwin Free		7930 Rocky Ridge Rd. Thurmont								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>														
4292 Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last (b) <u>AS CVD</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (1) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (1) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.														
22b. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22c. DATE SIGNED 9/11/80														
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PICKERT		22e. ADDRESS Thurmont Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/8/80		23c. NAME OF CEMETERY OR CREMATORIAL Creagerstown		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE				
24. FUNERAL DIRECTOR NAME <u>Lawrence E. Ricketts</u> ADDRESS <u>615 E. Main St.</u> Dailey Funeral Home		25a. DATE REC'D. BY REGISTRAR SEP 19 1980		25b. REGISTRAR'S SIGNATURE Patty McAdoo										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8023481	
1 - FOR STATE REGISTRAR			1a DECEASED NAME (TYPE OR PRINT)			1b FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR 2:00a.m.	
Anna Mary Gall									September 2, 1980				
3 SEX Female			4 RACE White			5 DATE OF BIRTH MONTH DAY YEAR January 26, 1900			6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland			7b CITIZEN OF WHAT COUNTRY? U. S. A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County			MD.	
10 CITY OR TOWN OF DEATH Taneytown,			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11510 Simmons Rd.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b KIND OF BUSINESS OR INDUSTRY				
13a STATE Maryland			13b COUNTY Frederick			13c CITY OR TOWN Taneytown			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS 11510 Simmons Rd.	
14 FATHER'S NAME Thomas			15 MOTHER'S MAIDEN NAME Nina									LAST Morrison	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO 215-14-9392			17 INFORMANT Janet Ann Hess			ADDRESS Md. 21787				
18 CAUSE OF DEATH Enter only one cause per line or (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost b. DUE TO, OR AS A CONSEQUENCE OF Chronic Premature Ventricular Contractions c. DUE TO, OR AS A CONSEQUENCE OF ASCVD > 1 yr												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a I certify that (i) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (ii) (we) last saw _____ the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (iii) (we) did not view the body of the deceased.													
22b SIGNATURE Alan Carroll M.D.			22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22d. DATE SIGNED Sept. 2, 1980				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan Carroll M.D.			22e ADDRESS S. Seton Ave. Emmitsburg, Md. 21727										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 4, 1980			23c NAME OF CEMETERY OR CREMATORIAL Blue Ridge			23d LOCATION CITY OR TOWN Thurmont Frederick Md.			STATE	
24 FUNERAL DIRECTOR NAME John M. Stiles			ADDRESS Emmitsburg, Md.			25 DATE REC'D. BY REGISTRAR SEP 8 1980			25 REGISTRAR Signature				
DHMH-16 50M7/77 (VRA 15 (4))													

1000 JOURNAL OF CLIMATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and complete my filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 0 2 3 4 8 2			
1 - FOR STATE REGISTRAR					REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR	2b HOUR		
Cyrus NMI GAMBRILL					September 20, 1980	3:00 P.M.		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
Male		White		Oct. 15 <sup>th</sup> , 1896		83		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
Colorado		U.S.A.				Frederick County, MD		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Frederick		Homewood Retirement Center		Executive		Baking Industry		
13a STATE		13b COUNTY		13c CITY OR TOWN		13d STREET ADDRESS		
Maryland		Frederick		Frederick		117 Record Street		
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Cornelius Staley		Annie				Helfenstein		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		
Yes		W. W. I		214-10-2094		117 Record Street		
				Cyrus Gambrill, Jr.		Frederick, Md. 21701		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4392				Cardiovascular disease		4 yrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.				DUE TO, OR AS A CONSEQUENCE OF (c)		5 yrs		
				Accompaniment				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED		
Dr. A. T. Brice, M.D.						9/22/80		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS						
Dr. A. T. Brice, M.D.		Jefferson, Maryland 21755						
23a BURIAL, CREMATION, REMOVAL (SPECIAL)		23b DATE		23c NAME OF CEMETERY OR CREMATORIUM		23d LOCATION CITY OR TOWN		
Burial		Sept 22, 1980		Mt. Olivet Cemetery		Frederick, Frederick, Md. STATE		
24 FUNERAL DIRECTOR Smith, Madieley, Keeney, Baskford Funeral Home 106 East Church St., Frederick, Md. 21701				25a REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
				SEP 23 1980		Linda Bradley		

11

3938

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE												8	0	2	3	4	8	3
CERTIFICATE OF DEATH												REG. NO. 9780						
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
WILLARD			ABNER GORDON						9 7 80			1047 P.M.						
3 SEX M			4 RACE W			5 DATE OF BIRTH MONTH 12 DAY 8 YEAR 18			6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS			IF UNDER 18, AGE MONTHS (1-12) DAYS (1-31) HOURS (0-23) MINUTES (0-59)						
7a. BIRTHPLACE COUNTRY MD			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH FREDERICK COUNTY MD									
10 CITY OR TOWN OF DEATH FREDERICK			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION FREDERICK MEMORIAL HOSP						12a. USUAL OCCUPATION CARPENTER			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE MD			13b. COUNTY FREDERICK			13c. CITY OR TOWN FREDERICK			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 5532 QUINN RD						
14. FATHER'S NAME Sydnor			MIDDLE C.			LAST Gordon			15. MOTHER'S MAIDEN NAME Avery E. Bush									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO 214 16 1291			17. INFORMANT Mrs. Mildred Layton Gordon			18. CAUSE OF DEATH Enter only one cause per line for a, b, and c. PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE a) 4149 DUE TO, OR AS A CONSEQUENCE OF b) ISCHEMIC HEART DISEASE Conditions, if any, which gave rise to immediate cause a), stating the underlying cause lost 4149 YEARS			ADDRESS						
18. CAUSE OF DEATH Enter only one cause per line for a, b, and c. PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE a) 4149 DUE TO, OR AS A CONSEQUENCE OF b) ISCHEMIC HEART DISEASE Conditions, if any, which gave rise to immediate cause a), stating the underlying cause lost 4149 DUE TO, OR AS A CONSEQUENCE OF c) ATHEROSCLEROSIS YEARS																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a HYPERTENSION																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I this hospital) attended the deceased from 9 7 80 to 9 7 80, and that (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on 9 6 80, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death)																		
22b. SIGNATURE S. Calia MD			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9-7-80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. KATAN MD			22e. ADDRESS 335 PARK AVE FREDERICK MD 21701															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept 10 1980			23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Memorial			23d. LOCATION CITY OR TOWN FREDERICK			COUNTY		STATE				
24. FUNERAL DIRECTOR NAME Rephalecy			ADDRESS 120 17th Market St			25. DATE RECEIVED BY REGISTRAR SEP 15 1980			25. REGISTRAR'S SIGNATURE D. Murphy, M.D.									

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1000 0 1000 0 1000 0  
1000 0 1000 0 1000 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	0	2	3	4	8	4	
										REG. NO.							
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR 22 22 M					
			William Ignatius Gouker						9/30/80								
3 SEX Male			4 RACE White			5 DATE OF BIRTH Month Day Year August 7, 1896			6 AGE (IN YEARS LAST BIRTHDAY) 84			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HR HOURS MIN			
7a BIRTHPLACE COUNTRY Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD								
10 CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer			12b KIND OF BUSINESS OR INDUSTRY Hospital					
13a STATE Maryland			13b COUNTY Frederick			13c CITY OR TOWN Frederick			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 247 East Church Street					
14 FATHER'S NAME John			15 MOTHER'S MAIDEN NAME Minnie														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. I			17 INFORMANT Mrs. Bulah Gouker, Frederick, Md. 21701			ADDRESS 247 East Church Street								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			4140 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS, HEART DISEASE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
			DUE TO, OR AS A CONSEQUENCE OF (c) WITH COMPLETE HEART BLOCK														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a CEREBRAL ISCHEMIA																	
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that (I) (the hospital) attended the deceased from 1965, 19, to Sept 30, 1980, that (I) (the last saw the deceased alive on Sept 30, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b SIGNATURE Gillian F. M. Endors Jr. MD										22c DATE SIGNED Oct 1, 1980							
22d PHYSICIAN'S NAME (TYPE OR PRINT) Gillian F. M. Endors Jr. MD			22e ADDRESS 810 Toll House Ave, Frederick, MD 21701														
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Oct. 3, 1980			23c NAME OF CEMETERY OR CREMATORIAL St. John Cemetery			23d LOCATION CITY OR TOWN Frederick, Frederick, Md.								
24 FUNERAL DIRECTOR Smith, Fadley, Keeney, Basford Funeral Home 106 East Church St., Frederick, Md. 21701									25a DATE REC'D. BY REGISTRAR Oct 8 1980			25b REC'D. BY F. J. Kelly					

000 8708

## TO HOSPITAL OR ATTENDING PHYSICIAN The letter retained by the hospital or attending Physician.

**TO HOSPITAL OR ATTENDING PHYSICIAN** The law requires that the death certificate be executed within 24 hours after death is reported by the hospital or attending physician.

**TO FUNERAL DIRECTOR** After this certificate has been signed by the attending physician and completely filled in by the funeral director, **Page 2** should be detached for use as the burial/Mental Hygiene permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

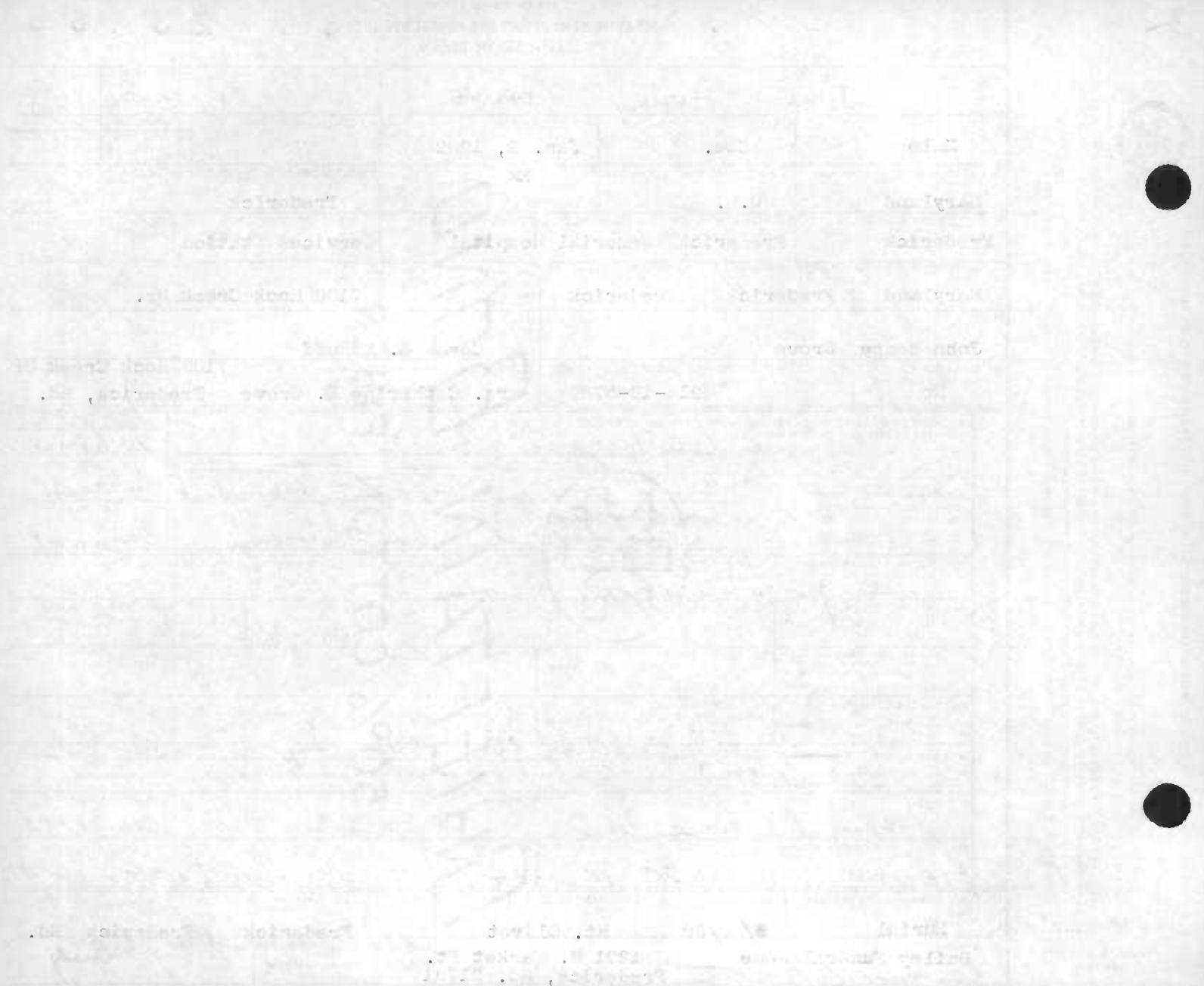
**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_  
HMH-16 30M 2/80  
(VRA 15.4)

DHMH-16 30M 2/80  
(VRA 15, 4)

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 23485							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
JOHN HENRY			(DROVE)			9-3-80			10 <sup>40</sup>		AM						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
Male		Cau.		Jan. 2, 1902			78			MONTHS	YEARS	MONTHS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Maryland		U.S.					Frederick										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Frederick		Frederick Memorial Hospital										Services Station					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Maryland		Frederick		Frederick						7109 Rock Creek Dr.							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
John Henry Grove			Cora E. Huff														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			7109 Rock Creek Dr					
No			214-10-5739			Mrs. Catherine E. Grove			Frederick, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
410- Cardiogenic shock													10 hours				
DUE TO, OR AS A CONSEQUENCE OF: (b) Arterial, extensive, recurrent myocardial aerobic, recurrent myocardial aerobic, recurrent myocardial													4 days				
(c) atherosclerosis, heart disease													5 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Pancygripituitarism																	
19a. DATE OF DEATH		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
Aug 30, 1980										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (1) the deceased attended the deceased from Aug 30, 1980, to Sep 3, 1980, that in (my) (his) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED									
Henry V. Chase MD								Sep 3 1980									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Henry V. Chase MD		804 Toll House Ave Frederick, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY		23f. STATE					
Burial		8/6/80		Mt. Olivet			Frederick			Frederick		Md.					
24. FUNERAL DIRECTOR		ADDRESSEES REC'D. BY REPORTER			25. DATE REC'D. BY REPORTER			26. REGISTERED & STAMPED									
Dolley Funeral Home		1201 N. Market St.			SEP-9 1980			Dolley									
Lawrence C. Fuchs		Frederick, Md. 21701															



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 4 6 6

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
				MYRL	ELIZABETH	GUE	September	1	1980	8: 76 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female		White		Month Day Year Dec. 8, 1901			78			IF UNDER 14 HRS. 8 23	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
Maryland		U.S.A.					Frederick Co., MD			Frederick	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
Frederick Memorial Hospital											
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		14. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 110 Fairview Ave.		
14. FATHER'S NAME FIRST Charles		MIDDLE H.		LAST Linton			15. MOTHER'S MAIDEN NAME FIRST Susanna		MIDDLE May		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		215-03-6124		Nadine Magers, 2900 Gillis Falls Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>											
410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDI INFARCTION</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (the hospital) attended the deceased from <u>1 Sept.</u> 19 <u>80</u> , to <u>1 Sept.</u> 19 <u>80</u> , that (1) (we) lost soul the deceased alive on <u>1 Sept.</u> 19 <u>80</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.											
22b. SIGNATURE <u>George L. Smith Jr. M.D.</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									22f. DATE SIGNED <u>1 Sept. '80</u>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE
Burial		9-4-1980		Pine Grove			Mt. Airy, Carroll, Md.				
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
SEP 8 1980									merry mullany		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death.

retd by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or once.





TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4 mos.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 3 4 8 1					
REG. NO.																	
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
			Sister Mary Louise Hansberry										Sept. 17,, 1980				1:10 p m
3 SEX			4 RACE			5 DATE OF BIRTH							6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			White			MONTH DAY YEAR			MARRIED <input type="checkbox"/>		NEVER MARRIED <input checked="" type="checkbox"/>		89	MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8			WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania			USA										Frederick MD				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY								
Emmitsburg			Villa St. Michael, Emmitsburg, Md.			Teacher			Dgtrs. of Charity								
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET ADDRESS					
Md.			Frederick			Emmitsburg			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			400 S. Seton Avenue					
14. FATHER'S NAME			MIDDLE			LAST			15 MOTHER'S MAIDEN NAME			LAST					
John James Hansberry									Sarah Ann Cassidy								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS								
No			061-42-0147-J1			Sr. Josephine-Villa St. Michael, Emmitsburg											
18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Probable Cardiac Arrhythmia</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF AS CVD																	
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Recent fractured hip and hypothyroidism</i>																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a I certify that (if this hospital) attended the deceased from _____, 19 _____, to _____, 19 _____, that (I) (we) last saw the deceased alive on _____, 19 _____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.																	
22b SIGNATURE <i>Alan Carroll M. D.</i>			22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED Sept. 17, 1980											
22d PHYSICIAN'S NAME (TYPE OR PRINT) Alan Carroll M. D.			22e ADDRESS S. Seton Ave. Emmitsburg, Md. 21727														
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Sept.19,1980			23c NAME OF CEMETERY OR CREMATORIAL St. Joseph's			23d LOCATION CITY OR TOWN Emmitsburg, Frederick Md.			COUNTY STATE					
24 FUNERAL DIRECTOR NAME John M. Skiles, 210 W. Main St. Emmitsburg, Md.			ADDRESS SET 22 1980			25a DEATH BY REGISTRATION 25b REGISTRATION NUMBER											

1970-10-12

1970-10-12

1970-10-12

1970-10-12

1970-10-12

1970-10-12

1970-10-12

1970-10-12

1970-10-12

1970-10-12

1970-10-12

1970-10-12

## TO HOSPITAL OR ATTENDING PHYSICIAN. The retained by the hospital or attending physician

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, reigned by the hospital or attending physician.

should be detached for use on the Womans Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 4 8 8

REG. NO

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
Edgar William Hill						9	17	80		1:15 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
Male		White		Month	Day	Year	78	YRS							
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington DC		U.S.									Frederick K MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Frederick md.		Montevue County Home						None							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13a. STREET ADDRESS			
13a. STATE MD.		13b. COUNTY Frederick		13c. CITY OR TOWN Rt. 13 Box 52								Montevue La. Fred. Md.			
14. FATHER'S NAME			FIRST Edgar	MIDDLE William	LAST Hill	15. MOTHER'S MAIDEN NAME			FIRST Jennie	MIDDLE Elizabeth	LAST Golden	ADDRESS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. NO			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
			220-48-2496			Mrs. Barbara Hildebrand Box Box 52			5 min						
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						Cardiac arrest						10 yrs			
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b)						ASND									
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9/1/80 to 9/17/80, that (I) (we) lost saw the deceased alive on 9/1/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED		9/18/80	
22c. SIGNATURE						DEGREE						ATTENDING PHYSICIAN		MEDICAL DIRECTOR	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						<input checked="" type="checkbox"/> PHYSICIAN		<input type="checkbox"/> PHYSICIAN	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN	
Burial						9-20-80						Resthaven Mem. Gar.		Fred	
24. FUNERAL DIRECTOR NAME						ADDRESS						25. DATE REC'D. BY REC'D. BY		25b. REC'D. BY	
G. Douglas Stauffer						Rt. 10 Box 66 Fred						SEP 24 1980		1980	



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 now becomes  
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director  
should be detached for use at the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be laid over the 72 hour  
with the State Seal. It is marked or Mental Hospital or to burial, cremation, or removal  
IMPORTANT: If Item 21 is marked or Mental Hospital or other traumatic event, the medical examiner  
should be called and advised.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

23489

1 DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST RAYMOND LESLIE HOFFMAN, SR.				REG. NO.						
3 SEX Male				4 RACE White		5 DATE OF BIRTH MONTH January 21, 1920		6 AGE (IN YEARS LAST BIRTHDAY) 60	7b BIRTHPLACE STATE OR FOREIGN COUNTRY Virginia	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County	2b HOUR 235 P	
10 CITY OR TOWN OF DEATH Frederick				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital				12b USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Guard	12b KIND OF BUSINESS OR INDUSTRY Security					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b STATE Maryland	13b COUNTY Frederick	13c CITY OR TOWN Brunswick	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 220 9th Avenue 21716
14 FATHER'S NAME FIRST MIDDLE LAST Everitt P. Hoffman				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada V. Baker										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b SOCIAL SECURITY NO. WW 2		17 INFORMANT ANNIE V. HOFFMAN		ADDRESS 220 9th Avenue Brunswick, Md. 21716						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <u>respiratory arrest</u>														
DUE TO OR AS A CONSEQUENCE OF (b) <u>COPD</u> <u>multiple causes</u>										2 weeks				
DUE TO OR AS A CONSEQUENCE OF (c) <u>small cell carcinoma</u> <u>long</u>										6 mo				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b														
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>1/1/64</u> to <u>9/1/80</u> that (I) (we) lost saw the deceased alive on <u>9/1/80</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										22c DATE SIGNED <u>9/4/80</u>				
22b PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. G. Rosser</u>				22e ADDRESS <u>4400 E. 36th Street</u>										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Sept. 8, 1980		23c NAME OF CEMETERY OR CREMATORIAL REST HAVEN MEMORIAL GARDENS		23d LOCATION CITY OR TOWN Frederick, Md.		COUNTY		STATE				
24 FUNERAL DIRECTOR NAME John T. Williams				100 Petersville Road Funeral Home Brunswick, Md. 21716				25b REGISTRAR'S SIGNATURE						



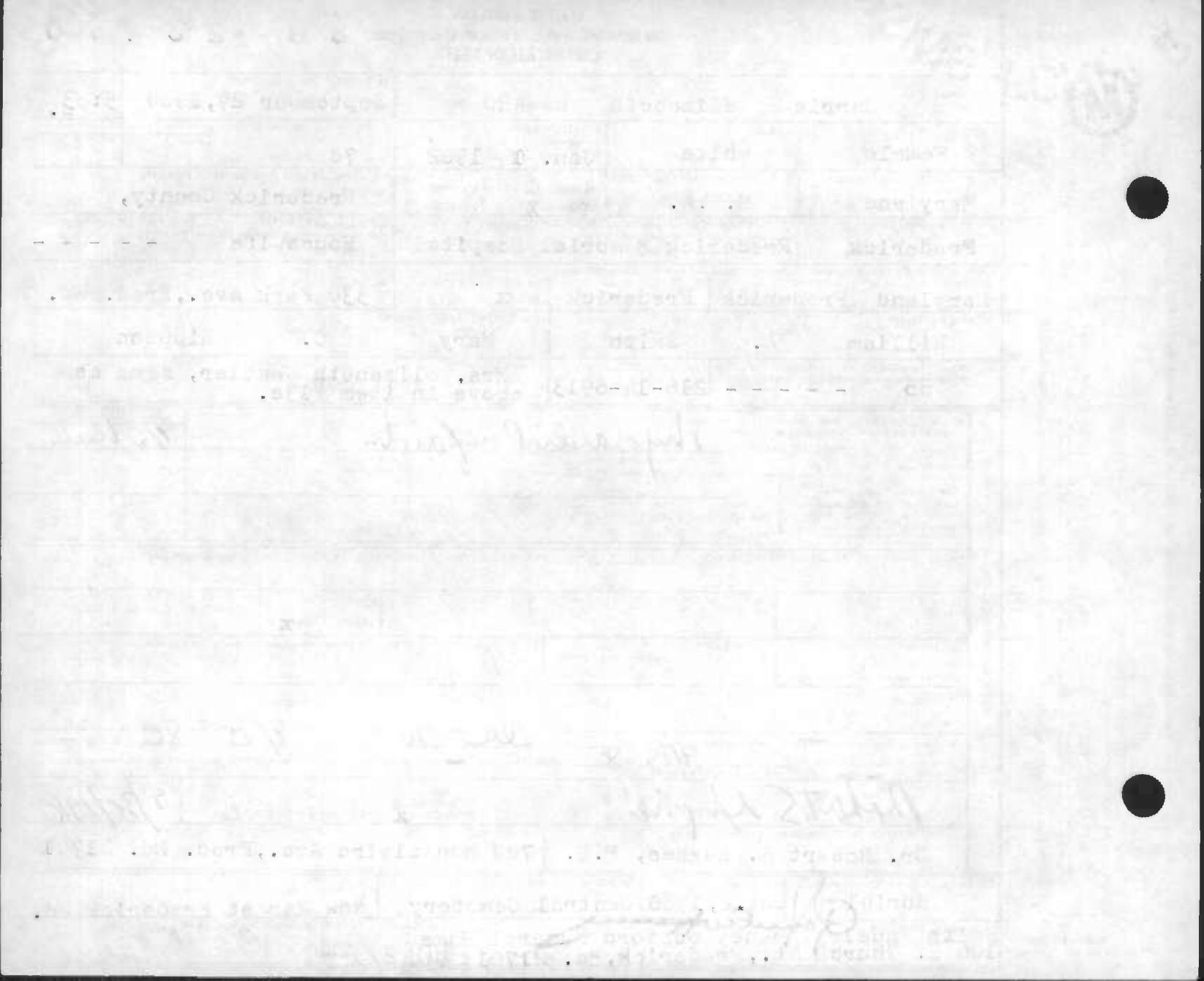
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

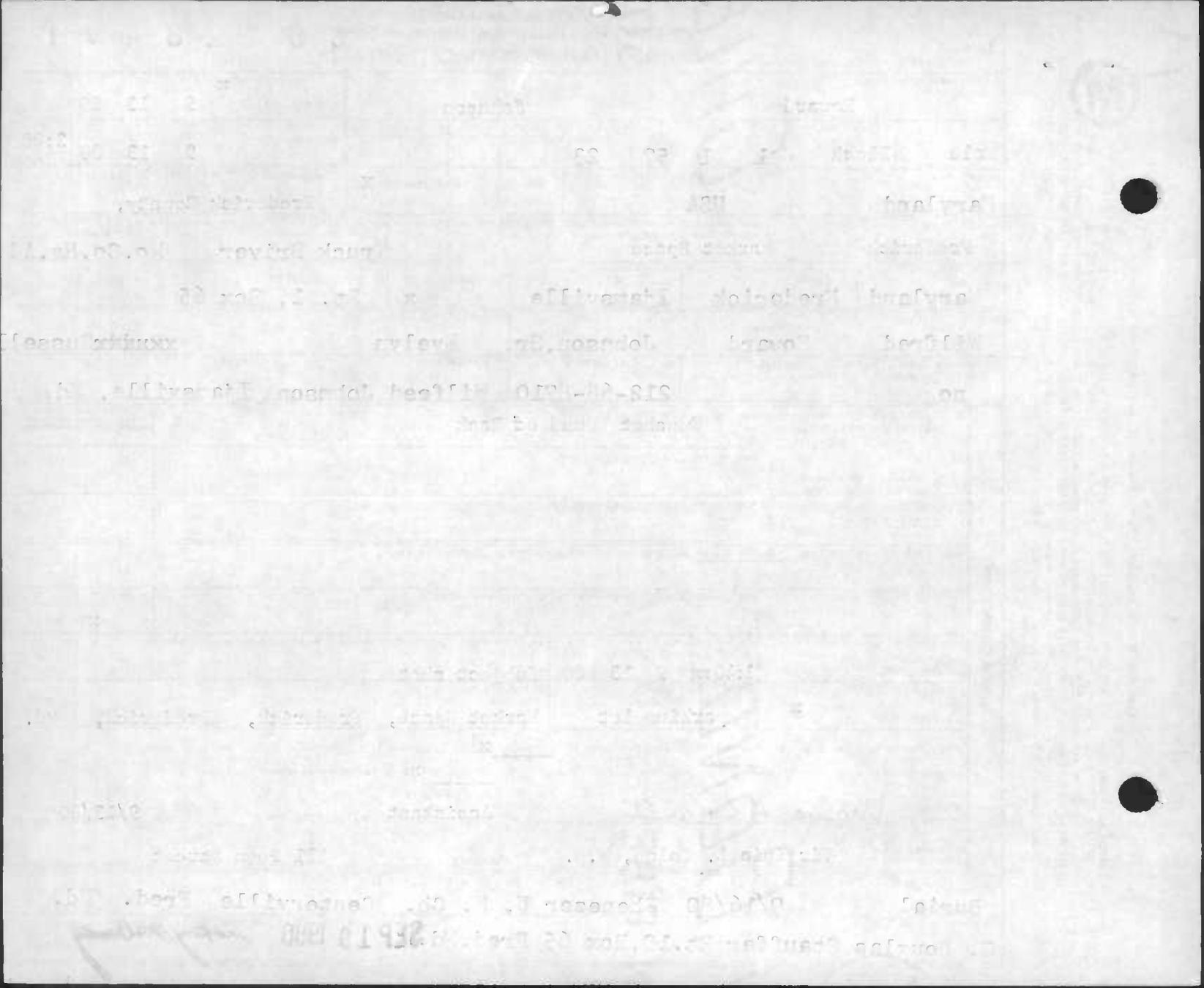
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 23490								
										REG. NO.								
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
		Carrie Elizabeth HOWARD										September 29, 1980					5:53 P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (IN YEARS LAST BIRTHDAY)		7		# UNDER 1 YEAR		# UNDER 24 HRS				
Female		White		Jan. 9 1902				YRS				MONTHS		DAYS		HOURS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.												Frederick County, MD				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY								
Frederick		Frederick Memorial Hospital				Housewife												
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d INSIDE CITY LIMITS?		13e STREET ADDRESS						
13a STATE Maryland		13b COUNTY Frederick		13c CITY OR TOWN Frederick		YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>		13e STREET ADDRESS 338 Park Ave., Fred. Md.								
14 FATHER'S NAME FIRST		MIDDLE		LAST		15 MOTHER'S MAIDEN NAME FIRST				MIDDLE		16 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
William		A.		Smith		Mary				C.		Rippeon						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO				17 INFORMANT Mrs. Elizabeth Wastler, same as above in item #13e.												
no		216-14-6913																
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)										19 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										20								
410- Myocardial infarction										21								
DUE TO, OR AS A CONSEQUENCE OF (b)										22								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE							
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9/15 1980 and that in (my) ( ) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death										22b. SIGNATURE Dr. Robert S. Hughes, M.D.								
22c DEGREE										22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22e. DATE SIGNED 9/30/1980				
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS 700 Montclair Ave., Fred. Md. 21701																
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE Burial Oct 2, 1980		23c NAME OF CEMETERY OR CREMATORY Central Cemetery				23d LOCATION CITY OR TOWN New Market		COUNTY	STATE							
24a FUNERAL DIRECTOR Smith, Fadley, Keeney Basford Funeral Home 106 E. Church St., Frederick, Md. 21701		25a DATE REC'D. BY REGISTRAR Oct 3 1980				25b REGISTRAR'S SIGNATURE D. B. Preedy												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5023491	
1- STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) Howard Johnson						2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 9 13 80					
3 SEX Male		4. RACE Black		5 DATE OF BIRTH MONTH 1 DAY 1 YEAR 57		6 AGE (IN YEARS (LAST BIRTHDAY) 23 YRS.		7 IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0		8 IF UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN 0		2b. DATE PRONOUNCED DEAD <input checked="" type="checkbox"/> 9 13 80	
7a. BIRTHPLACE Maryland		7b. CITIZEN OF WHAT COUNTRY? USA						7c. DATE RECORDED BY REGISTRAR 24. FUNERAL DIRECTOR NAME G. Douglas Stauffer ADDRESS Rt. 10, Box 65 Fred. Md.					
8. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Market Space						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver					
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Ijamsville		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS Rt. 1, Box 65					
14. FATHER'S NAME Wilfred		MIDDLE Howard		LAST Johnson, Sr.		15. MOTHER'S MAIDEN NAME Evelyn		16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-68-8710						17. INFORMANT Wilfred Johnson, Ijamsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9654 Gunshot Wound of Back												IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.	
DUE TO, OR AS A CONSEQUENCE OF												(b) DUE TO, OR AS A CONSEQUENCE OF	
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:40 <input checked="" type="checkbox"/> 9 13 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot						21d. LOCATION STREET Market Space, Frederick, Md.		CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) parking lot		21f. MEDICAL EXAMINER M.D. Assistant									
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) Virginia L. Dolan	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS						DATE SIGNED 9/13/80					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/16/80		23c. NAME OF CEMETERY OR CREMATORIAL Ebenezer U. M. Ch.						23d. LOCATION CITY OR TOWN Centerville Fred. Md.		COUNTY STATE	
24. FUNERAL DIRECTOR NAME G. Douglas Stauffer		ADDRESS Rt. 10, Box 65 Fred. Md.						25a. DATE REC'D. BY REGISTRAR SEP 19 1980		25b. REGISTRAR'S SIGNATURE Victory McElroy			
BP													
DHMH-17 (VR A15 M-15) 15M 7/76													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

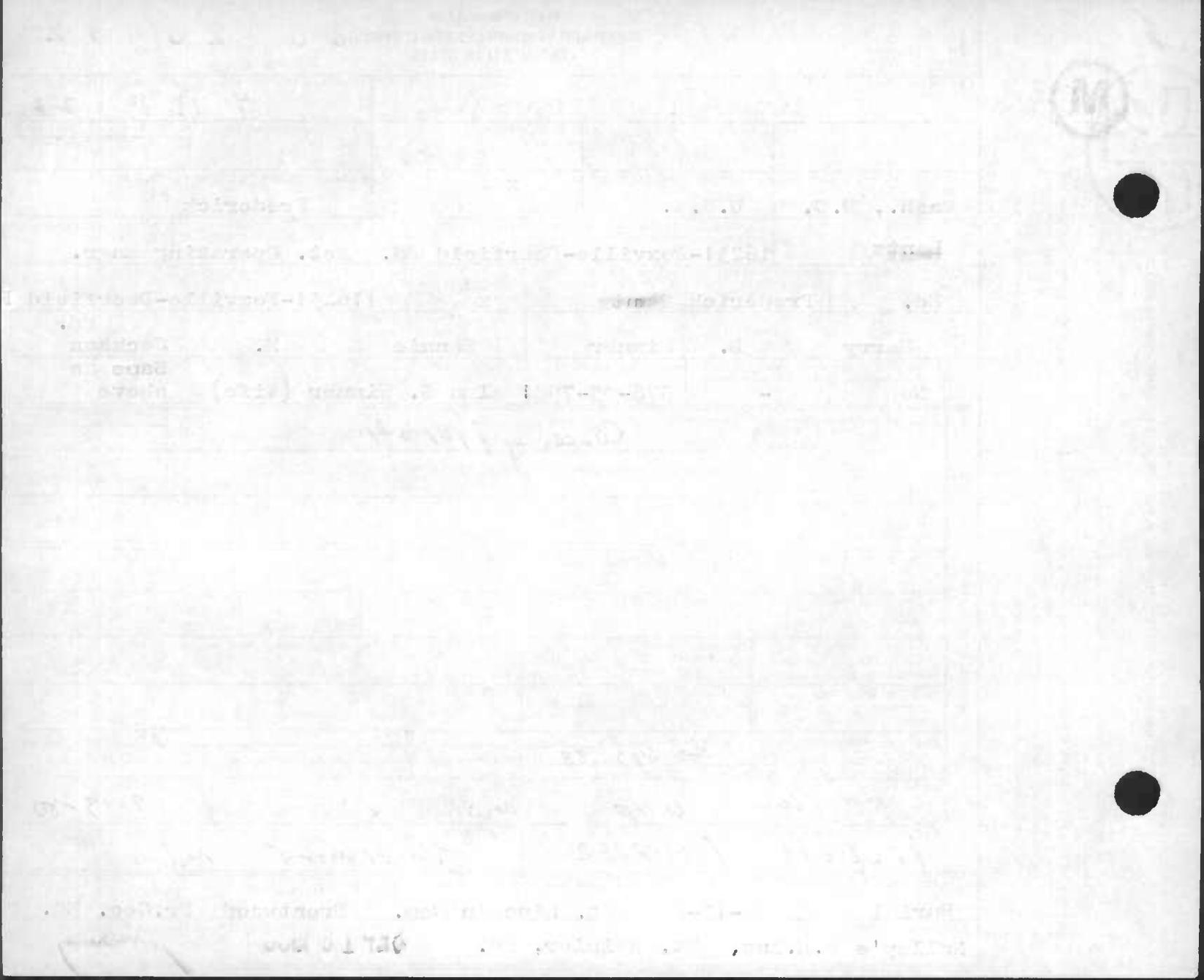
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 3 4 9 2

1 DECEASED NAME (TYPE OR PRINT)	FIRST Carl	MIDDLE L.	LAST Kinner	2a DATE OF DEATH MONTH 9 DAY 13 YEAR 80	2b HOUR 24 M
3 SEX M	4 RACE W	5 DATE OF BIRTH MONTH 6 DAY 18 YEAR 09	6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS	7 IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0	8 IF UNDER 24 HRS MONTHS 0 DAYS 0 HOURS 0 MIN 0
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Frederick	MD	
10 CITY OR TOWN OF DEATH Lantz	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16251-Foxville-Deerfield Rd.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Operating Engr.	
13a STATE Md.	13b COUNTY Frederick	13c CITY OR TOWN Lantz	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 16251-Foxville-Deerfield	12b. KIND OF BUSINESS OR INDUSTRY Rd.
14 FATHER'S NAME FIRST Harry	MIDDLE B.	LAST Kinner	15 MOTHER'S MAIDEN NAME FIRST Fannie	MIDDLE M.	LAST Jackson
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. -	17 INFORMANT Alma S. Kinner (Wife)	17 ADDRESS Same as above	18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 185- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 19a DATE OF OPERATION					
19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 19 17 to 19 80, that (I) (we) last saw the deceased alive on 5-21-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.					
22b. SIGNATURE Licker / WHITE		22c. DEGREE M.D.	22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED 9-13-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Licker / HARPER		22e. ADDRESS Thurmont Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-15-80	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cem.	23d. LOCATION CITY OR TOWN Brentwood	COUNTY STATE Pr. Geo. Md.
24. FUNERAL DIRECTOR NAME Nalley's F.H.Inc.		ADDRESS Mt. Rainier, Md.	25a. DATE REC'D. BY REGISTRAR SEP 10 1980	25b. REGISTRAR'S SIGNATURE J. Bradley	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3 RETAIN PAGE 3 FOR YOUR FILE. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 80 2 3 4 9 3						
1- STATE REGISTRAR			1 DECEASED NAME TYPE OR PRINT)			FIRST Ralph			MIDDLE Vincent			LAST Knox, Jr.			2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> 9 29 1980 M			
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Mar. 16, 1951			6 AGE (IN YEARS LAST BIRTHDAY) 29 YRS.			7 IF UNDER 1 YR. MONTHS DAYS			8 IF UNDER 24 HRS. HOURS MIN			2c. DATE PRONOUNCED DEAD 9 29 1980 M 2:10A M		
7b. BIRTHPLACE STATE OR FOREIGN COUNTRY Gettysburg, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County MD											
10 CITY OR TOWN OF DEATH North of Frederick		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) US route 15			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			12b. KIND OF BUSINESS OR INDUSTRY Meat Processor										
13a. STATE Maryland		13c. CITY OR TOWN Carroll			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET ADDRESS 259 E. Balto. St.										
14. FATHER'S NAME FIRST Ralph		14. MIDDLE Vincent			14. LAST Knox, Sr.			15. MOTHER'S MAIDEN NAME FIRST Virginia			15. MIDDLE LAST Kelly							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-58-4845			17. INFORMANT Ralph Knox, Sr.			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Taneytown, Md. 21787										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY 2:10A M 9/29/80			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in truck/truck collision												
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway			21f. LOCATION STREET US Route 15, North of Frederick, Frederick Co, MD CITY OR TOWN COUNTY STATE												
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE <i>HR Guard</i>		22b. TITLE (SPECIFY) M.D. Assistant			22c. MEDICAL EXAMINER			22d. DATE SIGNED 9/29/80										
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.		22e. ADDRESS 111 Penn Street, Balto., MD 21201																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 2, 1980			23c. NAME OF CEMETERY OR CREMATORIUM St. Joseph's Cemetery			23d. LOCATION CITY OR TOWN Taneytown, Carroll, Maryland										
24. FUNERAL DIRECTOR NAME Skiles Funeral Home, 136 E. Balto St. Taneytown, MD		24. ADDRESS Md. 21787			25a. DATE REC'D. BY REGISTRAR OCT 3 1980			25b. REGISTRAR'S SIGNATURE <i>Linda Schleifer</i>										
BP																		
DHMH - 17 (VR A15 ME (51)) 15M 7/76																		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please ~~remove~~ money be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80	23494						
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Henry Thomas Lee												9 18 80						1:40 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)										
Male			Caucasian			MONTH Mar. 9, 1908			72										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Pa.			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Frederick Co.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS INDUSTRY										
Frederick			Frederick Memorial Hosp.			Foreman			Apple Orchard						MD				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Md.			Fred.			Frederick						24 Water St.							
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			16. MIDDLE			17. LAST				
John			K.			Lee			Mary			Eliza			Rushenberger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
XX Yes			W. W. II			218-07-4360			Virgie Lee Frederick, Md.			21701			6 AM 191.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL LUNG CANCER</u>																			
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9-8-80</u> 19 <u>80</u> to <u>7-12-80</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9-12-80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <u>Arthur G. Parson, M.D.</u>												DEGREE							
22c. MEDICAL CERTIFICATION ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>9/15/80</u>																
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN				
Burial			Sept. 20, 1980			Mt. Olive Cem.			Mars			Alleg.			STATE Pa.				
24. FUNERAL DIRECTOR NAME Gladhill Co. Middletown, Md. 21769			ADDRESS			25a. DECEASED BY REMOVAL			25b. REMOVAL'S SIGNATURE <u>Henry Lee</u>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Please do not delay.

retained by the hospital or attending physician.

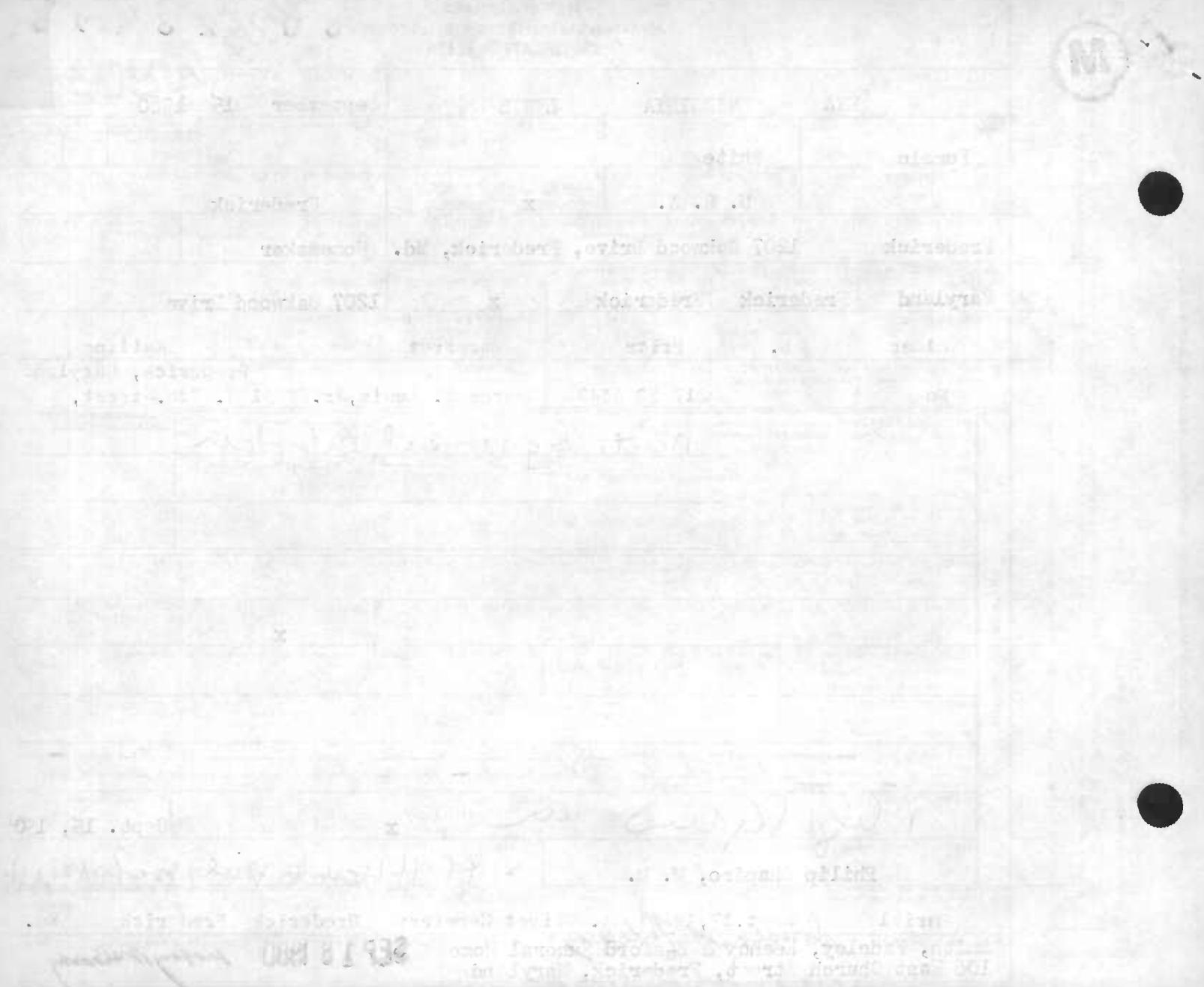
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 4 9 5

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
EVA			VIRGINIA LEWIS			September	15	1980		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		M IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female		White		✓		✓				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Frederick		
10 CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
13a STATE Maryland		13b COUNTY Frederick		13c CITY OR TOWN Frederick		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1207 Oakwood Drive		
14 FATHER'S NAME FIRST Elmer		MIDDLE E.		LAST Fritz		15 MOTHER'S MAIDEN NAME FIRST Margaret		LAST Railing		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		217 32 6542		George E. Lewis, Jr. 7951 W. 7th Street,		Frederick, Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>										
410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
1b)										
DUE TO, OR AS A CONSEQUENCE OF 1c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a I certify that (I) <u>Philip Shapiro</u> attended the deceased from <u>10-31</u> 19 <u>72</u> to <u>2-25</u> 19 <u>80</u> that (I) <u>Philip Shapiro</u> last saw the deceased alive on <u>2-25</u> 19 <u>80</u> and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (I) <u>did not</u> view the body after death.										
22b SIGNATURE <u>Philip Shapiro</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED Sept. 15, 1980
23a PHYSICIAN'S NAME (TYPE OR PRINT)		22d ADDRESS <u>1400 1/4 House Rd, Frederick, MD 21801</u>								
Philip Shapiro, M. D.										
23b BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL		23d LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		Sept. 17, 1980		Mt. Olivet Cemetery		Frederick		Frederick	Md.	
24 FUNERAL DIRECTOR Shadley, Keeney & Basford Funeral Home 106 East Church Street, Frederick, Maryland		25a DATE SEP 18 1980		25b BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Victor Maloney</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	23496
										REG. NO.	
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR	
1 DECEASED NAME Austin (TYPE OR PRINT)			William	McGaha	September 28, 1980		12:35 P.M.				
3 SEX Male			4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Aug. 15, 1915	6 AGE (IN YEARS LAST BIRTHDAY) 65 years YRS		IF UNDER 18 YEARS MONTHS DAYS HOURS MIN.				
7a BIRTHPLACE STATE OR FOREIGN Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD						
10 CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH DECEASED LAST ADDED)				12a USUAL OCCUPATION Mechanic		12b KIND OF BUSINESS OR INDUSTRY Government		
13a STATE Maryland			13b COUNTY Frederick	13c CITY OR TOWN Frederick	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 400 Elm Street					
14 FATHER'S NAME FIRST Claude			MIDDLE	LAW McGaha	15. MOTHER'S MAIDEN NAME FIRST Marriett		MIDDLE	LAST Whitter			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. W. W. II	16c	17 INFORMANT Mrs. Jane McGaha, 400 Elm St., Frederick, Md.		ADDRESS				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ADENOCARCINOMA OF LUNG &amp; ESOPHAGUS</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN		COUNTY	STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did/ did not view the body after death.										22c DATE SIGNED 9/28/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>G. WINNAN</i>			22e ADDRESS PREDERICK HOSPITAL								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Oct. 1, 1980	23c NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	23d LOCATION CITY OR TOWN Frederick, Frederick, Md. STATE						
24 FUNERAL DIRECTOR <i>Robert C. Bagford</i> Smith, Fadeley, Keeney, Bassford Funeral Home 106 East Church St., Frederick, Md. 21701			25a. DATE REC'D. BY REGISTRAR OCT 6 1980				25b. REGISTRAR'S SIGNATURE <i>Henry Murphy</i>				

USA 8700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 3 4 9 1		
REG. NO.														
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
			Charles Cleveland Mercer						9-6-80			1:50 P.M.		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
Male		White		March 10, 1886			94							
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED WIDOWED			9 BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Frederick County, MD							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY						
Frederick		Frederick Memorial Hospital			Machinist			Steel Company						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)														
13a STATE		13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Frederick		Frederick						606 Maxwell Avenue				
14. FATHER'S NAME		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME			MIDDLE			LAST	
Charles		E.		Mercer			Mary			Ellen Virginia			Stone	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
No			None 214-10-2868			Mrs. Mirian C. Himes.			9810 Masser Road			Frederick, Md. 21701		
18 CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4039 Cardiovascular bypass + shock												24 hours		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) Post-Operative Renal Failure												36 hours		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>arterio (or) nephrosclerosis</i>												5 years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a I certify that (or) this hospital) attended the deceased from saw the deceased alive on above, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		9/11/80 19 80			9/6/80 19 80			9/6/80 19 80			th (or) (we) last			
22b SIGNATURE					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED			
(22d. PHYSICIAN'S NAME (TYPE OR PRINT))											9/8/80			
Dr. Robert L. Kaufman, M.D.								22e ADDRESS			804 Toll House Ave., Frederick, Md. 21701			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE			23c NAME OF CEMETERY OR CREMATORIAL			23d LOCATION CITY OR TOWN			COUNTY		STATE	
Burial		Sept 10, 1980			Mt. Olivet Cemetery			Frederick, Frederick, Md.						
24 FUNERAL DIRECTOR		24b DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE									
Smith, Fadley, Keeney, Balford Funeral Home														
106 East Church St., Frederick, Md. 21701								SEP 15 1980						

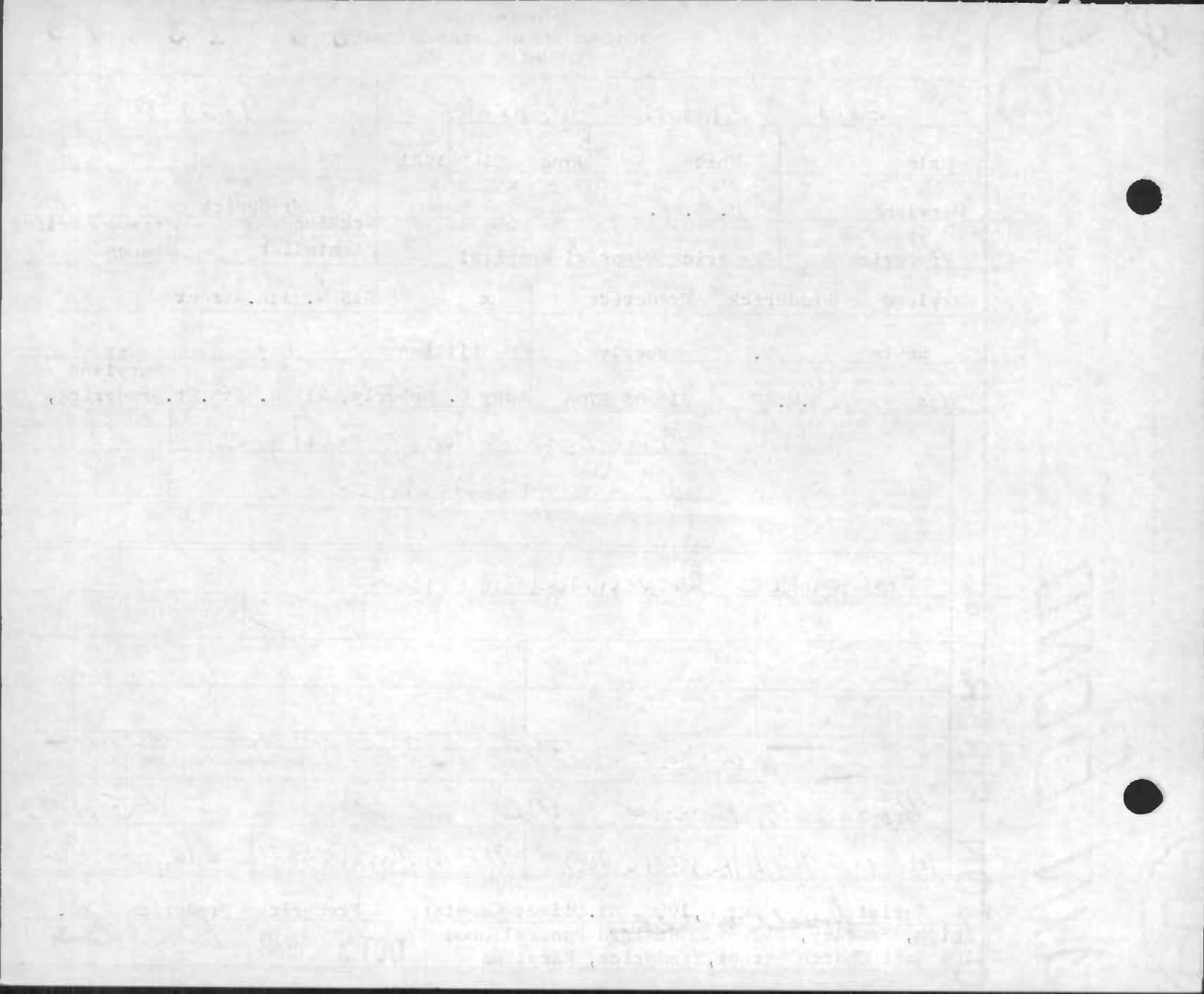


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																		
REG. NO. 8 0 2 3 4 9 8																		
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR									
Earl Edward Moberly									9-29-80									
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) 59			7b HOUR M								
				June 21 1921														
7a BIRTHPLACE COUNTRY Maryland		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Frederick			10 CITY OR TOWN OF DEATH Frederick								
										Machine CUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Installer		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital						
12a STATE Maryland		13b COUNTY Frederick		13c CITY OR TOWN Frederick			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 215 W. 5th Street								
14. FATHER'S NAME FIRST Lewis			MIDDLE E.			LAST Moberly			15 MOTHER'S MAIDEN NAME FIRST Lillian			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. W.W.#2 219 05 2706		17 INFORMANT Ruby L. Moberly, 215 W. 5th St. Frederick,		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congested Heart Failure</u> 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) <u>Cardiomyopathy</u> (c) <u></u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Stasis ulcers, Inguinal hernia</u>																		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN		COUNTY STATE							
22a I certify that (I) <input type="checkbox"/> attended the deceased from <u>Sept</u> 1979 to <u>29 Sept</u> 1980 that (I) <input type="checkbox"/> last saw the deceased alive on <u>29 Sept</u> 1980 and that in my <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (II) <input type="checkbox"/> did not view the body after death												22c DATE SIGNED 29 Sept 80						
22b SIGNATURE <u>Morris Wilkinson</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Morris A. Wilkinson MD</u>			22e ADDRESS <u>707 N. Market St Frederick Md</u>															
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Oct 2 1980			23c NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery			23d LOCATION CITY OR TOWN Frederick			COUNTY STATE Frederick Md.						
23e NAME Fayley, Keeney & Bassey Funeral Home 106 East Church Street, Frederick, Maryland						25a DATE REC'D. BY REGISTRAR OCT 3 1980			25b REGISTRAR'S SIGNATURE <u>Henry Moberly</u>									

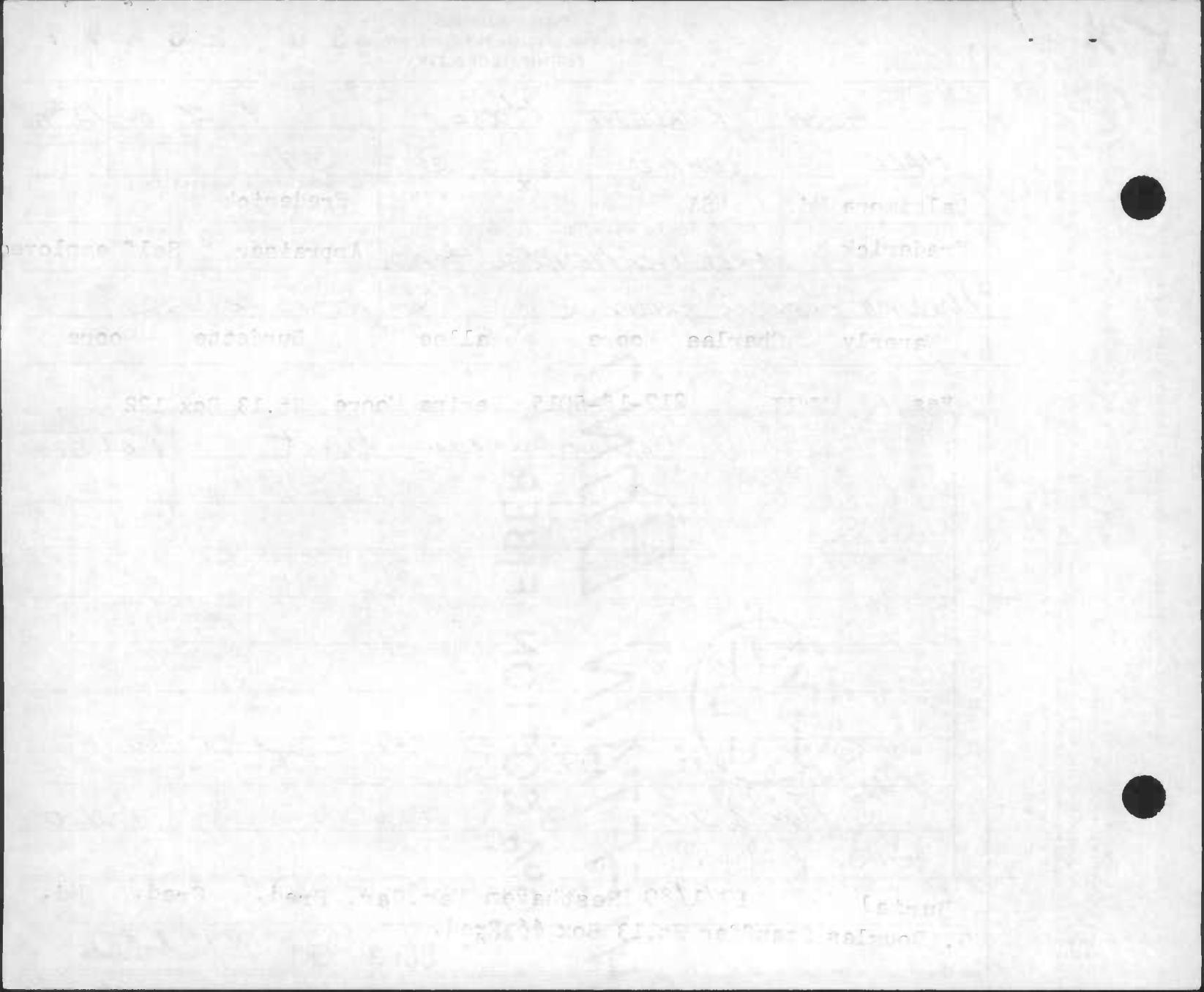


TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examine must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 3 4 9 9 CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR			REG. NO.								
1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST		
HUGH BURDETTE MOORE											
3 SEX			4 RACE			5 DATE OF BIRTH			7a DATE OF DEATH		
MALE			WHITE			MONTH DAY YEAR			9 29 80		
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8			6 AGE (IN YEARS LAST BIRTHDAY)		
Baltimore, Md.			USA			X MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			59 YRS		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Frederick			FREDERICK MEMORIAL Hospital			Appraiser			Self employed		
13a STATE			13b COUNTY			13d INSIDE CITY LIMITS?			13e STREET ADDRESS		
MARYLAND			FREDERICK			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt 13 Box 122		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		
Waverly Charles Moore			Malliee			yes			217-18-5015		
16c IMMEDIATE CAUSE OF DEATH			17 INFORMANT			18b SOCIAL SECURITY NO.			ADDRESS		
PART 1. DEATH WAS CAUSED BY 4140			Regina Moore			217-18-5015			Rt. 13 Box 122		
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF ASHD			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a			DUE TO, OR AS A CONSEQUENCE OF ASHD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH About 1/2 hour		
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on 10/25 19 79, and that in <input type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I) <input type="checkbox"/> (we) did not view the body after death.									COUNTY STATE		
22b. SIGNATURE W. J. Riddick						DEGREE MD			22c. DATE SIGNED 9/30/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. J. Riddick, MD.			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/1/80			23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Mem. Cem. Fred. Fred. Md.			23d. LOCATION CITY, STATE		
24. FUNERAL DIRECTOR G. NAME Douglas Stauffer			ADDRESS Rt. 13 Box 66			25a. DATE REC'D. BY REGISTRAR OCT 3 1980			25b. REGISTRAR'S SIGNATURE Lillian McAlister		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

73  
FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

80 23500

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
Darryl Everett NORWOOD						September 14, 1980			5 A M			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		May 10, 1945			35					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		U.S.A.					Frederick Co.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Mt. Airy		R#4, Box 366A			Dry Wall Installer							
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS				
Maryland		Frederick		Mt. Airy				R# 4, Box 366A				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT
		Norval	L.	Norwood	Sarah		Yes			215-40-0412		Janet M. Norwood, Item 13
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)		PART I. DEATH WAS CAUSED BY			IMMEDIATE CAUSE (a)			Amyotrophic Lateral Sclerosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
											18 months	
					DUE TO, OR AS A CONSEQUENCE OF							
					(b)							
					DUE TO, OR AS A CONSEQUENCE OF							
					(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a I certify that (I) (this hospital) attended the deceased from November 19, 1969, to present, 19_____, that (I) (we) last saw the deceased alive on Dec. 20, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE		DEGREE			ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED			
William B. Culwell MD									Sept. 14, 1980			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS										
William B. Culwell MD		4 culwell Driv - Mt. Airy, Md. 21771										
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL			23d LOCATION CITY OR TOWN			23e COUNTY		
Burial		Sept. 17, 1980		Locust Grove			Mt. Airy, Frederick, Md.			STATE		
24 FUNERAL DIRECTOR NAME		ADDRESS			25a DATE REC'D. BY REGISTRAR			25b REGISTRATION NO.				
Olin L. Molesworth, P.A.		Damascus, Md.			SEP 17 1980							

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THE FEDERAL BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8023501		
1 - FOR STATE REGISTRAR			2 - DATE OF DEATH MONTH DAY YEAR							REG NO.		
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	3 - DATE OF DEATH MONTH DAY YEAR				7b HOUR 3C AM		
WILLIAM J. E. NULL						September 10 1980						
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 22 1903			6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7b HOUR 3C AM			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U. S. A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Frederick		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
10 CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator		12b TRADE OR BUSINESS OR INDUSTRY Ed. Education	
13a STATE Maryland		13b COUNTY Frederick		13c CITY OR TOWN Frederick		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 100 West 13th Street		MD		
14 FATHER'S NAME Edgar		MIDDLE G.	LAST Null	15 MOTHER'S MAIDEN NAME Bessie			MIDDLE May	LAST Hiltner				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 214 10 5488		17 INFORMANT Mrs. Letitia B. Staley Null (Same as item 13a)			18b APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days					
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4019		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Neuroleptic Edena</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Neuroleptic (at time of Pd. Edena)</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a I certify that (1) (this hospital) attended the deceased from <i>9/10/80</i> to <i>9/10/80</i> , that (1) (we) last saw the deceased alive on <i>9/10/80</i> and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.												
22b SIGNATURE <i>R. L. Kaufmann, M.D.</i>			22c DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED Sept. 10, 1980			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Kaufmann, M.D.			22e ADDRESS 804 Toll House Ave. Frederick, Maryland									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Sept. 13, 1980		23c NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery			23d LOCATION CITY OR TOWN Frederick		COUNTY	STATE	
24. FUNERAL DIRECTOR Name, <i>Robert L. Kaufmann, M.D.</i> ADDRESS, <i>804 Toll House Ave. Frederick, Maryland</i>			25a DATE REC'D BY REGISTRAR'S STAMP Signature \$EP 15 1980									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH	8 0 2 3 5 0 2
1a DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH	MONTH DAY YEAR
1b FIRST MIDDLE LAST Edward Patrick O'MALLEY				2b HOUR 8:30 P M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 16, 1910	
6a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 70 years	
7c IF UNDER 1 YEAR MONTHS DAYS		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD	
10 CITY OR TOWN OF DEATH Adamstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 5703 Doubs Road		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	
13a STATE Maryland		13b COUNTY Frederick		12b KIND OF BUSINESS OR INDUSTRY Farming	
13c CITY OR TOWN Adamstown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14 STREET ADDRESS 5703 Doubs Road	
14 FATHER'S NAME FIRST MIDDLE LAST Patrick O'Malley		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa McHale			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) none 213-64-7262		17 INFORMANT ADDRESS Mrs. Veronica Nunemaker, Adamstown, Md. 21710	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Preventable acute M.I.</u> <span style="float: right;">36 years</span> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>Aug. 17</u> , 1980, to <u>30 Sept.</u> , 1980, that (I) (we) lost the deceased alive on <u>24 Sept.</u> , 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Charles H. Conley, Jr., M.D.</u>		DEGREE		22c DATE SIGNED 10-3-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Charles H. Conley, Jr., M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct 4, 1980		23c NAME OF CEMETERY OR CREMATORIAL St. Joseph Cemetery	
24 FUNERAL DIRECTOR Richard C. Bader Smith, Fadley, Keeney, Basford Funeral Home 106 East Church St., Frederick, Md. 21701		25a DATE REC'D. BY REGISTRAR Oct 8, 1980		25b REGISTRAR'S SIGNATURE <u>Henry McElroy</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, page 3 should be detached for use as the burial-trust form. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 3 5 0 3
REG. NO.				
1. FOR STATE REGISTRAR	FIRST <b>Mazie</b>	MIDDLE <b>T.</b>	LAST <b>PERHAM</b>	2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 4, 1980</b>
1. DECEASED NAME (TYPE OR PRINT)	2b. HOUR <b>12:45<sup>A</sup></b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 16, 1886</b>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>94 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick</b>	
10. CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Nursing Center</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Antique Dlr.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>MD</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>New Market</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>James</b>	MIDDLE <b>R. Thompson</b>	LAST	15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>578 24 7305D</b>	17. INFORMANT <b>Margaret Aiken</b>	ADDRESS <b>10420 Mercado Way Gaithersburg, Md.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arterio-venous Heart Disease</i> (c) <i></i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <i>Acute Gastritis, Gastroenteritis, Arteriosclerosis</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 26</b> , 19 <b>73</b> , to <b>Sept. 4</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>August 28</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did not) view the body after death.	22b. SIGNATURE <i>Gilcin F. Meadows Jr.</i>	22c. DEGREE <i>MD</i>	22d. DATE SIGNED <b>Sept. 9, 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gilcin F. Meadows, Jr., MD.</b>	22e. ADDRESS <b>810 Toll House Ave., Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Sept. 6, 1980</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet</b>	23d. LOCATION CITY OR TOWN <b>Frederick</b>	
24. FUNERAL DIRECTOR NAME <b>Olin L. Molesworth P.A., Damascus, Md.</b>	ADDRESS	25a. DATE REC'D. BY REGISTRAR <b>SEP 8 1980</b>	25b. REGISTRAR'S SIGNATURE <i>Henry May</i>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD 'PENDING' IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

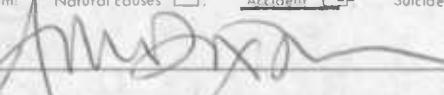
## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3023504		
1. DECEASED NAME (TYPE OR PRINT)			FIRST Charlotte			MIDDLE May			LAST Remsberg			2a DATE KNOWN OF DEATH ESTIMATED	2b MONTH DAY YEAR	2c HOUR
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	9. NEVER MARRIED DIVORCED	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY			
female	white	Feb. 13, 1895	85 RS.	Md.	U.S.A.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Frederick	Frederick Memorial Hospital	Housewife	Own Home			
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS										
Md.	Frederick	Middletown	23 E. Main St.											
14 FATHER'S NAME FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST									
AMOS	LIGHTER	REMSBERG	IDA	MAY	RENN									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS											
NO	215-44-9788	Laura Remsberg	21769 Middletown, Md.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries to the Chest with complications DUE TO, OR AS A CONSEQUENCE OF Unpended 10-31-80												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
78121 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.														
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject was passenger in truck auto collision												
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street	21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 40 near Hillcrest Drive, Frederick, Md.												
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Margarita A. Korell, M.D. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 9-2-80														
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			111 Penn St.								
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN Middletown					
Burial			Sept. 4, 1980			Reformed Cem.			Fred. Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Gladhill Co. Middletown, Md. 21769						SEP 11 1980			Larry McCreary					
BP														
DHMH - 17 (VR A15 ME 51) 15M 7/76														

1980 11 11 2001

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS EXECUTED THE CERTIFICATE, WRITING THE WORD "BENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 RETAIN PAGE 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5023505					
1. DECEASED NAME (TYPE OR PRINT)			FIRST DWIGHT			MIDDLE Leo			LAST RICE			2a. DATE KNOWN <input checked="" type="checkbox"/> ESTI. MONTH 8 DEATH MATED <input type="checkbox"/> DAY 30 YEAR 1980	2b. HOUR 11:39 p.m.				
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	9. DATE PRONOUNCED DEAD	10. MONTH 8 DAY 30 YEAR 1980	11. HOUR 11:39 p.m.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County								
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE Framer & Groover Optical Company			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Maryland			13b. COUNTY Frederick			13c. CITY OR TOWN Frederick			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 6913 Plantation Road					
14. FATHER'S NAME FIRST Garnett			MIDDLE L.			LAST Rice			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE M.			LAST Harley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 1971-1974			16c. INFORMANT Mrs. Debra L. Rice, 6913 Plantation Road, Frederick, Maryland 21701			16d. ADDRESS			16e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cranio-cerebral trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c) DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <del>XXX</del> MONTH DAY YEAR 1 P.M. 8-30-1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver -Occupant of auto/auto collision.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET Gas House Pike & Linganore Rd., Frederick Md.											
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE 												22b. TITLE (SPECIFY) Assistant MEDICAL EXAMINER					
23a. EXAMINER'S NAME (TYPE OR PRINT)			23b. ADDRESS 111 Penn St.			23c. DATE SIGNED 8-31-80											
23a. BURIAL, CREMATION, REMOVAL SPECIFIC			23b. DATE Sept. 4, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN Frederick								
24. FUNERAL DIRECTOR Smith Fadeley Keeney Basford Funeral Home 106 E. Church St., Frederick, Maryland 21701						25a. DATE REC'D. BY REGISTRAR SEP 4 1980			25b. REGISTRAR'S SIGNATURE 								
BP			DHHM-17 (VR A15 ME (5)) 15M 7.76														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
relinquished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 0 2 3 5 0 6				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH			MONTH			DAY			YEAR		2b HOUR		
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			MONTH			DAY			YEAR		2b HOUR		
Clyde H. Ridenour			Ridenour			1 26 09			9 5 80			11 AM				
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
M			W			MONTH DAY YEAR			71			MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD				
Maryland			U.S.						Frederick							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY							
Frederick			Frederick Memorial Hospital			Farmer										
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET ADDRESS				
Maryland			Frederick			Lantz			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4309 Foxville Rd.				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
Elmer T. Ridenour			Cora Lewis													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS							
No			219-14-9264			Miss Bessie E. Ridenour			4309 Foxville Rd.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY			19. DUE TO, OR AS A CONSEQUENCE OF			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
496- Conditions, if any, which gave rise to immediate cause of death, stating the underlying cause lost			b) <i>Respiratory failure</i>			ye										
IMMEDIATE CAUSE (a)			c) <i>Cold</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
21a DATE OF OPERATION			21b CONDITION FOR WHICH OPERATION WAS PERFORMED			21c AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21e TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a I certify that (I) (this hospital) attended the deceased from <i>9/13</i> 1980 to <i>9/13</i> 1980 that (I) (we) last saw the deceased alive on <i>9/13</i> 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b SIGNATURE						DEGREE										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS			M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22f DATE SIGNED		
P. C. E. R.			Thurmont, MD											9-5-80		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORIUM			23d LOCATION CITY OR TOWN			COUNTY		STATE		
Burial			9/9/80			Mt. Bethel			Foxville			Frederick		Md		
24 FUNERAL DIRECTOR NAME			25a DATE REC'D. BY REGISTRAR			25b RECORD MAINTAINS SIGNATURE										
Lawrence E. Ricken Dailey Funeral Home			615 E. Main St.			Thurmont, Md. 21788			SEP 19 1980			Larry McCrady				

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3 507

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First Lester	Middle Alfred	Last Rollins	2a. DATE OF DEATH Aug. 5, 1980	2b. HOUR 2:00 P.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 15 Jan. 1899	6. AGE (In years last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS    DAYS	IF UNDER 24 HRS HOURS    MIN.
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Frederick		
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) City employee		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 118 West 3rd. Street		
14. FATHER'S NAME James		Middle Alfred	Last Rollins	15. MOTHER'S MAIDEN NAME Ellen		Middle	Last Myers
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 220-30-9548		17. INFORMANT		Address	
<p>18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Metastatic Carcroma brain &amp; bone</i> APPROXIMATE INTERVAL 1991 BETWEEN ONSET AND DEATH 3 months.</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last.</p> <p>(b) <i>Rhabdomyoma cell tumor</i></p> <p>(c)</p>							
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p><i>Arterio - sclerotic cardio-vascular disease</i></p>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1959</u> to <u>Aug. 5, 1980</u>, that (I) (we) last saw the deceased alive on <u>Aug. 5, 1980</u>, one that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>							
22b. SIGNATURE <i>Bernard O. Thomas</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 8/5/80		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7 Aug 80	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet		23d. LOCATION (City or Town) Frederick	(County) Frederick	(State) Md.
24. FUNERAL DIRECTOR Robert E. Dailey & Son		ADDRESS 1201 N. Market St.	25a. REC'D BY REGISTRAR DATE AUG 11 1980		25b. REGISTRAR'S SIGNATURE <i>John J. O'Leary</i>		

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
rejoined by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please  
should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8023508		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Sandra E.M. Saulpaugh			Sandra E.M. Saulpaugh			8-6-80			2:16 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
F		W		May 25, 1905			75 YRS			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Neb.		U.S.					Frederick			MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Frederick		Frederick Memorial Hospital								Housewife		
12b. KIND OF BUSINESS OR INDUSTRY												
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Frederick		Thurmont					3 Victor Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Barton C. Bowman		Jane								Teter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Yes		W.W.II		506-07-6769			Robert K. Saulpaugh			3 days		
3481												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiogenic Shock</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe Hypoxemia</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Aspiration &amp; Hypoxemia &amp; CNS Death</i> 7 days												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 19-78 to 81-61, 19-80, that (I) (we) last saw the deceased alive on 81-61, 19-80, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Robert K. Saulpaugh</i>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/7/80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE 8/9/80			23c. NAME OF CEMETERY OR CREMATORIAL Blue Ridge			23d. LOCATION CITY OR TOWN Thurmont, Frederick, Md.			
24. FUNERAL DIRECTOR NAME R.L. Dalley & Son			ADDRESS 615 E. Main Thurmont, Md.			DATE OF DEATH OR Cremation AUG 15 1980			REGISTRATION NUMBER 1201 N. Market Frederick			



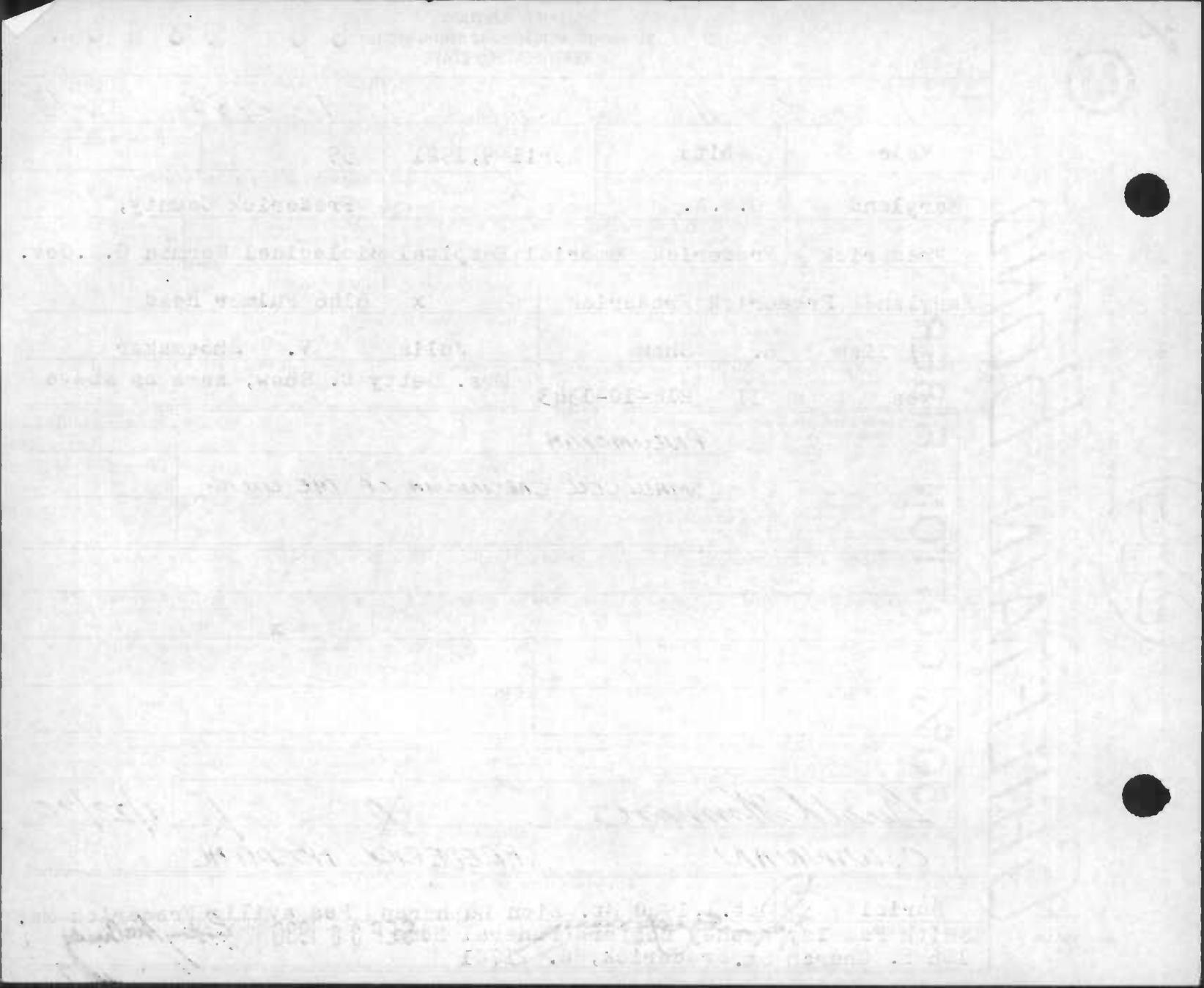
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8023509							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR									
Kenneth Wadrow Shaw				9/28/80			9	28	1980	6 45									
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR									
Male		White		Month Day Year April 9, 1921			59			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH									
Maryland		U.S.A.					Frederick County, MD.			Frederick									
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Frederick Memorial Hospital												Biological Forman U.S.Gov.							
13a. STATE Maryland												13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6146 Fulmer Road	
14. FATHER'S NAME FIRST William				MIDDLE H.		LAST Shaw		15. MOTHER'S MAIDEN NAME FIRST Julia		MIDDLE V.		LAST Shoemaker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT Mrs. Betty C. Shaw, same as above		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA											
16d. DUE TO, OR AS A CONSEQUENCE OF (b) SMALL CELL CARCINOMA OF THE LUNG						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and on the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 9/28/80							
22b. SIGNATURE G. Winnan		22d. DEGREE ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS FREDERICK HOSPITAL															
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE Burial Oct. 1 1980		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion Lutheran		23d. LOCATION CITY OR TOWN Frederick		COUNTY		STATE Frederick Md.									
24. FUNERAL DIRECTOR Smith Fadely		24b. DATE 106 E. Church St. Frederick, Md. 1701		24c. DATE 1980															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8023510
										REG. NO.
1 - STATE REGISTRAR			2a DATE OF DEATH							10851
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	P. M.	
JOHN HENRY SIGLER						Sept.	30, 1980			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male		Caucasian		June 16, 1887		93				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 BALTIMORE CITY OR COUNTY OF DEATH		MD.		
Md.		U.S.A.				Frederick Co.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
Frederick		Frederick Memorial Hospital		stone mason		building				
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS		
Md.		Fred.		Middletown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Mountain Church Rd.		
14 FATHER'S NAME		MIDDLE	LAST	FIRST	15 MOTHER'S MAIDEN NAME		MIDDLE	LAST		
JOHN		M.	SIGLER	SARAH				JONES		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		218-12-2283		Ralph Sigler		Middletown, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bilateral Pneumonia</i>										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER		21b TIME OF INJURY HOUR AM MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <i>Sept. 10, 1980</i> to <i>Oct. 1, 1980</i> , that (I) (we) last saw the deceased alive on <i>Sept. 1, 1980</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b SIGNATURE <i>Michael Befane</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/2/80				
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael Befane</i>		22e ADDRESS Box 17 Middletown, MD 21769								
23a BURIAL, CREMATION, REMOVAL (SPECIES) Burial		23b DATE Oct. 4, 1980		23c CEMETERY OR CEMATORIUM Locust Valley Bible Ch. Cem.		23d LOCATION CITY OR TOWN Middletown		COUNTY STATE Fred. Md.		
24 FUNERAL DIRECTOR NAME Gladhill Co. Middletown, Md. 21769		ADDRESS		25a DATE REC'D. BY REGISTRAR OCT 6 1980		25b REGISTRAR'S SIGNATURE <i>Michael Befane</i>				

Grid 3702

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 3 5 1					
1a DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		REG. NO.			
Gilmore W. STITLEY, SR.										802351			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR					
Male		White		Sept. 27, 1902		September 1, 1980		2 P.M.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Maryland		U.S.A.		77 yrs		9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, ONE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY							
Frederick		Frederick Memorial Hospital		Moulder		Iron & Steel Company							
13a STATE Maryland				13b COUNTY Frederick		13c CITY OR TOWN Frederick		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 203 E. Sixth Street			
14 FATHER'S NAME FIRST				MIDDLE		15 MOTHER'S MAIDEN NAME Effie		LAST		16b SOCIAL SECURITY NO 1921-1924 214-10-3199			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT Mrs. Geraldine Shelton, 129 East Sixth Street, Frederick, Md. 21701		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Yes										5 AM			
18b CAUSE OF DEATH (Enter only one cause per line for Part 1, 1b and 1c) PART 1 DEATH WAS CAUSED BY				IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		COPD		1045			
						DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21g I certify that (i) this hospital attended the deceased from saw the deceased alive on 9/1/80 at 10:00 AM above. (ii) (we) did not view the body after death.			21h LOCATION STREET 70 9/1/80					CITY OR TOWN 10:00		COUNTY 80			
21i SIGNATURE Dr. Timothy Hickey, M.D.			21j DEGREE MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9/1/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS Parkview Medical Center, Frederick, Md.										
Dr. Timothy Hickey, M.D.													
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE Sept. 4, 1980		23c NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery			23d LOCATION CITY OR TOWN Frederick		COUNTY STATE Frederick Md.			
Burial													
24 FUNERAL DIRECTOR Smith Facel, J. Keeney Bassford Funeral Home 106 E. Church St., Frederick, Md. 21701					25a DATE REC'D. BY REGISTRAR SEP 8 1980			25b REGISTRAR'S SIGNATURE Timothy Hickey					

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0827 8932

TO HOSPITAL OR ATTENDING PHYSICIAN. The l returned by the hospital or attending physician.

Page 3  
N  
y filled in by the funeral director  
should be filed within 72 hours of death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Katherine May				Stone		Sep 3 1980					11 45'		
REG. NO.													
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 22, 1895		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
						85 YRS		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County,							
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Tailoring Comp							
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 30 South <del>Market</del> Jefferson Street					
14. FATHER'S NAME FIRST John		MIDDLE E.		LAST Roberts		15. MOTHER'S MAIDEN NAME Elizabeth		16. ADDRESS 1507 South Main St., Mt. Airy, Md. 21777					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		16c. INFORMANT Mrs. Mildred Tawney,									
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		4511		Massive Pulmonary Embolus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Phlebothrombosis of deep											
		DUE TO, OR AS A CONSEQUENCE OF (c) Femoral Vein						Unknown					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a)													
19a. DATE OF OPERATION Aug 30 1980		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of left hip		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:00 a.m. 8/29/80 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) see above									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) home		21f. LOCATION STREET 30 S. Jefferson St. CITY OR TOWN Frederick COUNTY Md. 217									
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <u>Aug 29</u> , 1980, to <u>Sep 3</u> , 1980, that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>Sep 3</u> , 1980, and that (I) <input checked="" type="checkbox"/> my (or) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.		22b. SIGNATURE Henry V. Chase MD		DEGREE		22c. DATE SIGNED Sep 3, 1980							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry V. Chase MD		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 6, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN Frederick, Md.		23e. COUNTY Frederick, Md.		23f. STATE Md.			
24. FUNERAL DIRECTOR Smith, Fadley, Keeney, Basford Funeral Home 106 East Church St., Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR SEP 8 1980		25b. REGISTRAR'S SIGNATURE Henry V. Chase									

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. *BP*

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use in the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification must be completed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	23513		
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		Oren Wilbur Strine				2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
		OREN WILBUR STRINE				9-25-80					12:30AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		white		12 15 1891		88		MONTHS	YEARS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Walkersville		USA						Frederick					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (UNUSUAL HABITATION, GIVE ADDRESS)		12a. USUAL OCCUPATION (TYPE OF OCCUPATION OR WAY OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Frederick		Frederick Memorial Hospital		Miller		Md. Va. Mill							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17. INFORMANT (IF YES, GIVE WAR OR DATES)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
Maryland Frederick Walkersville		Francis Thomas Strine		Laura		no		212-93-3082		PART 1. DEATH WAS CAUSED BY  IMMEDIATE CAUSE (a) <i>Chronic congestive heart failure</i>			
										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) <input type="checkbox"/> (this hospital) attended the deceased from <i>15 Sept 80</i> , 19 <i>80</i> , to <i>25 Sept</i> , 19 <i>80</i> , that (I) <input type="checkbox"/> lost soul the deceased alive on <i>24 Sept</i> , 19 <i>80</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE <i>George J. Smith</i>		22c. DEGREE <i>A.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>25 Sept 80</i>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9/27/80		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Hope Cemetery		23d. LOCATION Woodsboro		Fred. Md.					
24. FUNERAL DIRECTOR G. Douglas Stauffer Rt. 10 Fred., Md.						25a. DATE REC'D. BY REGISTRAR OCT 3 1980		25b. REGISTRAR'S SIGNATURE <i>Patsy McCreedy</i>					

Burris

G. D. - 1964-01-27

Report of the Board of Inquiry

1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled in with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8023514				
											REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			Raymond Lee			Mr. Strine			2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			Raymond			Strine			9-17-80						3:30 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
male			white			MONTH DAY YEAR			77			YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			USA						Frederick							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Frederick			Frederick Memorial Hospital			Retail			Retail							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Frederick			Walkers.			49 Frederick St.							
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			S.			ADDRESS				
George			H.			Annie			S.			Walkersville				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
no			217-32-5128			Mabel V. Strine			30 minutes							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																
Cardiac Arrest																
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease 3 years																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Vascular Disease																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (the hospital) attended the deceased from 8/12/80 to 9/17/80, that (I/we) last saw the deceased alive on 9/12/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did not) view the body after death.																
22b. SIGNATURE Casper E. Cline III																
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DEGREE			22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			22h. DATE SIGNED 9/17/80				
Casper E. Cline III			804711 House Ave													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION							
Burial			9/19/80			Mt. Hope Cemetery			Woodsboro Fred.			Md.				
24. FUNERAL DIRECTOR NAME			G. Douglas Stauffer			24b. DATE OF REGISTRATION 10/24/80			24c. REGISTRATION NUMBER MD. 1000							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust permit. Then file in same stubbongen. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, in other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8023515

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Eleanor					Swire	9	27	80	9 30 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR			
Female		White		MONTH	DAY	YEAR	53	MONTHS	IF UNDER 24 HRS		
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Penns.		U.S..						FREDERICK			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
FREDERICK			FREDERICK MEMORIAL					HOUSEWIFE		MD	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
On STATE Maryland			13b. COUNTY Frederick		13c. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7503 Ann Place				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST Nicholais			FIRST Watlock		MIDDLE Bruce		MIDDLE Mary		LAST Kapral		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, ONE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17. INFORMANT		17e. ADDRESS				
No			096-22 836		Bruce W. Swire		7503 Ann Place				
18. CAUSE OF DEATH: (ENTER ONLY ONE CAUSE PER LINE FOR PART I, PART II, OR PART III)			18b. DUE TO, OR AS A CONSEQUENCE OF		18c. DUE TO, OR AS A CONSEQUENCE OF		18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE:			a. <i>Cardio pulmonary arrest</i>		b. <i>Myocardial infarction</i>		70 min				
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b):			c. <i>Diabetes</i>				2d				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
29a. MEDICAL CERTIFICATION			29b. DATE OF OPERATION					29c. CONDITION FOR WHICH OPERATION WAS PERFORMED		29d. AUTOPSY?	
										YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART II)				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>9/27/80</i> , to <i>July 70</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									STATE		
22b. SIGNATURE <i>Eleanor J. Swire</i>			22c. DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 8/30/80		23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Memorial Gar.		23d. LOCATION CITY OR TOWN Frederick		COUNTY Frederick Md.		
24. FUNERAL DIRECTOR NAME <i>Robert E. Swire</i>			ADDRESS 124 N. Main St.		25a. DATE REC'D. BY REGISTRAR SEP 30 1980		25b. REGISTRAR'S SIGNATURE <i>Patricia McBrady</i>				

1. *Introduction* 2. *Methodology* 3. *Results* 4. *Conclusion*

1. *Introduction* 2. *Methodology* 3. *Results* 4. *Conclusion*

1. *Introduction* 2. *Methodology* 3. *Results* 4. *Conclusion*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS PENDING, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT FOR 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8023516
1- STATE REGISTRAR			2a DATE KNOWN OF DEATH MONTH DAY YEAR ESTI. DEATH MATED 9 16 1980 537									
1. DECEASED NAME (TYPE OR PRINT) <b>BURNEICE MURIEL THOMAS</b>			MIDDLE <b>MURIEL</b>			LAST <b>THOMAS</b>			2b. DATE MONTH DAY YEAR PRONOUNCED DEAD 9 16 1980 537			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 18 12 68</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>68</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ARK.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK</b>				
10. CITY OR TOWN OF DEATH <b>FREDERICK</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FREDERICK MANORIAL</b>									
12a. USUAL RESIDENCE (IF IN NURSING HOME OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>FLA</b>			12b. STATE <b>HILLSBORO</b>			12c. CITY OR TOWN <b>TPMPP</b>			12d. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>			
13a. STATE <b>FLA</b>			13b. COUNTY <b>HILLSBORO</b>			13c. CITY OR TOWN <b>TPMPP</b>			13d. STREET ADDRESS <b>1212 E. COMMACHE</b>			
14. FATHER'S NAME FIRST <b>WILLIAM R.</b>			MIDDLE <b>CHILDRESS</b>			15. MOTHER'S MAIDEN NAME FIRST <b>MOLLIE E.</b>			Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. None			17. INFORMANT <b>DAVID THOMAS.</b>			ADDRESS <b>1212 East Commache</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  4999 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c) DUE TO, OR AS A CONSEQUENCE OF  Arteriosclerotic Cardivascular Disease			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the removals described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Robert J. Thomas</b>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
EXAMINER'S NAME TYPE OR PRINT) <b>Robert J. Thomas, M.D.</b>			TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER ADDRESS <b>812 Toll House Ave. Frederick, Md. 21701</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Sept 20, 1980</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Rome Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Proctorville, Lawrence, Ohio</b>			
24. FUNERAL DIRECTOR <b>Richard E. Basford</b> Smith, Fadeley, Keeney, Basford Funeral Home 106 East Church St., Frederick, Md. 21701			25a. DATE REMOVED BY FUNERAL DIRECTOR <b>SEP 19 1980</b>			25b. RE <b>Richard E. Basford</b>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 23517							
REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Madeline Capotolia Virts									9-8-80			8	4	AM	10 10 4 AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS							
Female		White		Sept. 15, 1906			73			MONTHS DAYS		HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD									
West Virginia		USA					Frederick County												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		Frederick Memorial Hospital										Housewife		Own Home					
13a. STATE Maryland												13b. COUNTY Frederick		13c. CITY OR TOWN Brunswick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 709 East Potomac Street 21716	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																	
Fred S. Moler		Pearl C. Shewbridge																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		213 74 3876		Orion J. Virts		709 East Potomac Street Brunswick, Md. 21716													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
410- Acute Cardiac arrest												45 minutes							
410- DUE TO, OR AS A CONSEQUENCE OF (b) Acute recurrent myocardial infarction 45 minutes																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																			
DUE TO, OR AS A CONSEQUENCE OF (c) Other underlying heart disease with healed 4 mo. + infarction																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (he/she/it) intended the deceased from 1980, to 1980, that (I) (he/she/it) lost saw the deceased alive on 1980, and that in (my) (his/her) opinion death occurred on the date and hour and from the causes stated (I) (he/she/it) (did) (did not) view the body after death.												22c. DATE SIGNED Sep 8 1980							
22b. SIGNATURE Henry V. Chase M.D.			DEGREE																
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22e. DATE SIGNED										
Henry V. Chase M.D.			804 Toll House Ave Frederick MD						Sep 8 1980										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE					
Burial			Sept. 11, 1980			Harpers Cemetery			Harpers Ferry, West Va.										
24. FUNERAL DIRECTOR NAME			100 Petersville Road ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
John T. Williams Funeral Home			Brunswick, Md.						SEP 17 1980			Henry McElroy							



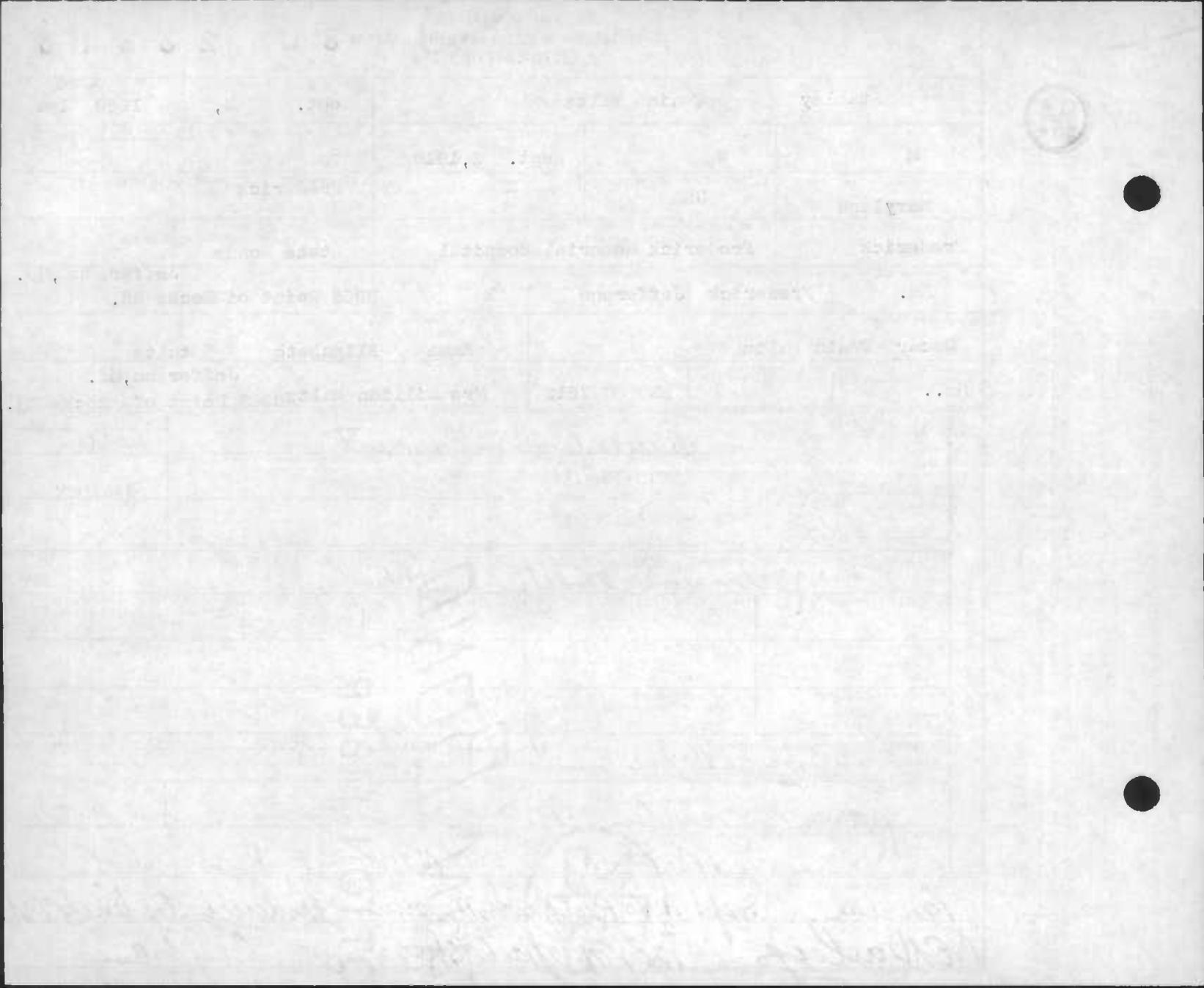
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8023518														
REG. NO.																										
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST Stanley			MIDDLE Twain			LAST Waltz			2a DATE OF DEATH MONTH Sept.			DAY 8,		YEAR 1980		2b HOUR 1pm				
3 SEX M			4 RACE W			5 DATE OF BIRTH MONTH Sept.			DAY 3,		YEAR 1910		6 AGE (IN YEARS LAST BIRTHDAY)			7a MONTH YRS		8 MONTHS DAYS		9 HOURS MIN						
7b BIRTHPLACE COUNTRY Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED X			NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Frederick			10 CITY OR TOWN OF DEATH Frederick		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) State Roads			12b KIND OF BUSINESS OR INDUSTRY Jefferson, Md.		
13a STATE Md.			13b COUNTY Frederick			14 CITY OR TOWN Jefferson			13d INSIDE CITY LIMITS? YES X NO <input type="checkbox"/>			13e STREET ADDRESS 8368 Point of Rocks Rd.			14a FATHER'S NAME Oscar Twain Waltz			15 MOTHER'S MAIDEN NAME Emma Elizabeth Stultz								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No..			16b SOCIAL SECURITY NO. 220 30 7612			17 INFORMANT Mrs Lillian Waltz			18c ADDRESS Jefferson, Md.			18b APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden			18a CAUSE OF DEATH Enter only one cause per line for 18b and 18c PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 440 DUE TO, OR AS A CONSEQUENCE OF b) A S N D Conditions, if any, which gave rise to immediate cause of death stating the underlying cause last years			18c APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Hypertension Diabetes mellitus												19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that (I) this hospital attended the deceased from <u>9-4</u> 19 <u>67</u> to <u>9-8</u> 19 <u>80</u> that (I) (we) last saw the deceased alive on <u>8-21-80</u> 19 <u>80</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we did) did not view the body after death.												22b SIGNATURE Rex R. Martin MD			22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED 9-9-80								
22d PHYSICIAN'S NAME (TYPE OR PRINT) Rex R. Martin			22e ADDRESS 20 N Market Frederick MD			23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Sept 11, 80			23c NAME OF CEMETERY OR CREMATORIAL Resthaven Memorial			23d LOCATION CITY OR TOWN Frederick											
24 FUNERAL DIRECTOR NAME Rex R. Martin			25a DATE REC'D. BY REGISTRAR 1201 N. Market St.			25b REGISTRAR'S SIGNATURE Lily McBrady																				
BP			DMMH - 16 60M 1/75 (VRA 15 (4))																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 23519			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Raymond			Thomas	Wigington, Sr.		8 4			80	9	05 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 18 YEARS		IF UNDER 24 HRS				
Male		White		July 21, 1910		70			YEARS		MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA							Frederick County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Frederick		Frederick Memorial Hospital										Carman		Railroad	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13e. STREET ADDRESS			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Maryland		Frederick		Brunswick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1108 2nd Avenue 21716						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE		LAST					
		Thomas	H.	Wigington	Bessie			---		Metz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE LATITUDE AND LONGITUDE AT DEATH							
No		212 14 7477		Raymond T. Wigington, Jr.		107 A Street 21716		Brunswick, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for Part 1a)												PART 1. DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a)												2000 Hertocyles malignant			
DUE TO, OR AS A CONSEQUENCE OF												Lymphoma Segm Gm. eton			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												(b)			
DUE TO, OR AS A CONSEQUENCE OF												(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												Perforation Segm, abscess, fistula			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
7/21/80		Abcess & fistula										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED					
		P.M. 19				saw the deceased alive on 8/7/80, 1980, to 8/7/80, 1980, that (I) (we) last saw the deceased alive on 8/7/80, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		FRANK DAMATO		8/4/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
FRANK DAMATO		700 Montclair Ave Frederick													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE					
Burial		Aug. 7, 1980		Park Heights Cem.		Brunswick, Maryland									
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
John T. Williams		100 Petersville Road		Funeral Home Brunswick, Md.		AUG 16 1980		John T. Williams							

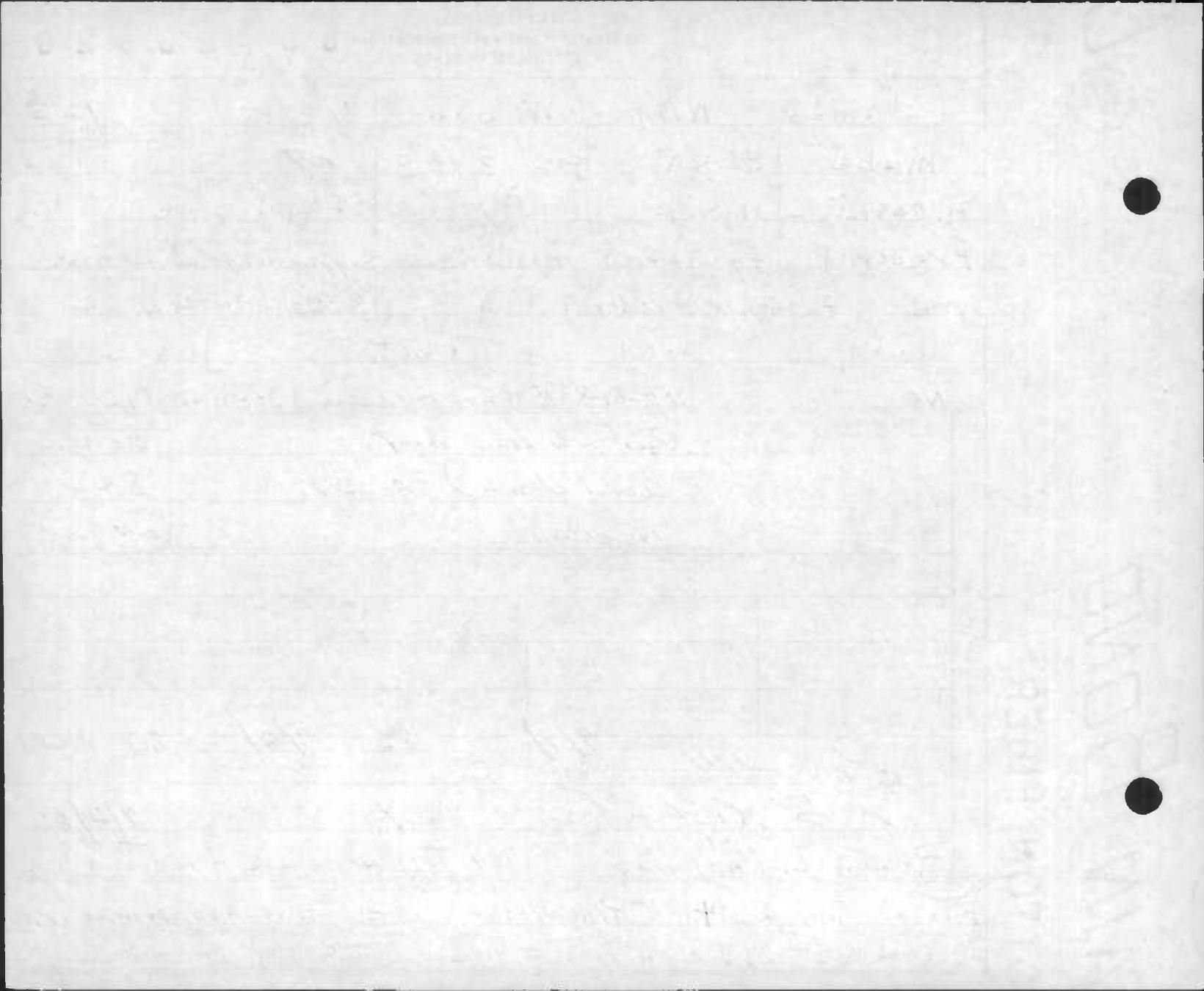


TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4  
relied on by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8023520				
REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
James NMN Wilson												9/2/80				12 17 M
3. SEX		4. RACE		5. DATE OF BIRTH MONTH			YEAR			6. AGE (IN YEARS LAST BIRTHDAY)						
MALE		BLACK		FEB			1913			67						
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
N. Carolina		U.S.A.								Frederick						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Frederick		Frederick Memorial										Supply technician		Dentist		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
MD		Frederick		Frederick						S 303 Waverly Drive						
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST				
UNKN				UNKN			Violet					JONES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT			16d. ADDRESS			16e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
NO		102-01-8395		Pearl B. Wilson			S 303 Waverly Drive			30 min.						
18. CAUSE OF DEATH Enter only one cause per line for a, b, and c. PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Reactive Arthritis</i>																
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Central Nervous System</i>																
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Exposure</i>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED								21c. AUTOPSY?		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
											YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21e. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (SEE OTHER MEDICAL EXAMINER)			21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)										
			P.M.			Falls										
21h. INJURY OCCURRED AT HOME <input type="checkbox"/> IN OFFICE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21j. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
			9/1/80						80		7/29		80			
22a. I certify that at this hospital attended the deceased from <u>9/1/80</u> to <u>9/2/80</u> and that in my (our) opinion death occurred on the date and hour and from the cause stated above. <u>He did not live 24 hours</u> and that I (we) did not view the body after death.																
22b. SIGNATURE <u>R. L. Kaufman</u> DEGREE																
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																
22d. DATE SIGNED <u>9/2/80</u>																
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS													
Robert L. Kaufman			804 Toll House Ave Frederick, MD													
23a. BURIAL/CREMATION/REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial - remains			8/4/1980			Pinewood Cemetery			Pinelawn Cemetery			Leesburg		MD		
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
C. E. HICKS			263 W. PATRICK ST MD						SEP 3 1980			Robert L. Kaufman				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8023521								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
JULIA									YEAGER			September 8, 1980			8:30 AM					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7a. IF UNDER 1 YEAR			7b. IF UNDER 24 HRS					
Female			White			Mar. 17, 1890			90			MONTHS DAYS			MONTHS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD								
Germany			USA						Frederick											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Frederick			Homewood Nursing Home			Housewife														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
Va.			McLean									6534 Gillans Road								
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			FIRST			LAST					
John			Kesmarik						Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS											
No			Unknown			Margaret Rinne, Daughter, Same as Above														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Cerebral vascular accident																				
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																				
{ (b) Cerebro vascular Disease																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 19 79 to SEPTEMBER 19 80 that (we) last saw the deceased alive on 7 September 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if (we) (did) (did not) view the body after death.)																				
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
Dr. George I. Smith															8/5/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			804 Toll House			Frederick, Md.								
Burial			23b. DATE SPECIFY 9-10-80			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN Suitland, P.G., Md.											
24. FUNERAL DIRECTOR NAME Funeral Home			ADDRESS Rd., Suitland, Md.			25a. DATE REC'D. BY REGISTRAR SEP 11 1980			25b. REGISTRAR'S SIGNATURE George I. Smith											

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